Health
Ontario

File No. .....

Date March 22, 1976

Memorandum to

Mr. L. C. Hales

From

Dr. B. A. Boyd

Re Scientologists

The Scientologists have abstracted from the literature a number of adverse comments. At Penetanguishene we do not use LSD as a magic drug but rather as a tool to aid in the psychotherapeutic process.

Finally may I say that the word "experimenting" in regard to the LSD program could be very misleading. We are not carrying out any procedure that is not designed to be therapeutic. We are, of course, attempting to study the results of these treatments in terms of program evaluation and we welcome the comments and opinions of qualified outside observers.

At Penetanguishene we have a Professional Advisory Committee, an Ethics Committee, a Research Committee and, of course, a Medical Advisory Committee. Treatment programs, including the use of LSD, are considered carefully and approved and monitored by this committee system. Our programs are also examined with great interest by many visiting groups, including judges, lawyers, psychiatrists and, of course, members of the two Review Boards and the Office of the Ombudsman. We also have a Legal Aid lawyer visiting the building twice monthly who can be seen by any patient. I do think that we are taking reasonable steps to protect the rights of our patients.

If I can be of any further help in clarifying this situation please contact me.

BAB/sdt

B. A. Boyd, M.D., F.R.C.P.[C]
Medical Director

Ministry of Health
Ontario

LSD #6

File No. .....

Date March 30, 1976

Memorandum to

Dr. D. C. Panday,
Senior Psychiatric Consultant,
Psychiatric Services,
6th Floor - 15 Overlea Blvd.,
TORONTO

From

Dr. B. A. Boyd,
Medical Director,
Mental Health Centre,
PENETANGUISHENE

Re - LSD -

For about ten years the Social Therapy Unit programme at Oak Ridge has included the use of a number of "defence-disrupting" drugs, including LSD. This programme was begun by Dr. E. T. Barker and more recently has been carried on by Dr. G. Maier.

During Dr. Barker's time there were 30 LSD treatments administered. During Dr. Maier's time there have been 55 treatments to the 1st of March, 1976 and there will be 12 more by the end of April. Three of the patients have had 3 treatments each, four have had 2, and the others, one.

Please find attached a copy of Dr. Barker's paper on Defence-Disrupting Therapy, a copy of Dr. Barker's paper LSD In A Coercive Milieu Therapy Program which has been submitted to the Canadian Psychiatric Journal, a copy of my report of March 22nd to Mr. Hales and copy of a letter sent to the Barrie Examiner by 40 Oak Ridge patients.

Dr. Maier has put his patients through a very careful period of preparation, lasting many weeks. Every effort is made to see that they understand the treatment and give 'informed' consent. "Trips" are carefully supervised and monitored on videotape for playback and pre-trip and post-trip psychological tests have been administered. Dr. Maier is working on a paper describing this aspect of his programme.

BAB/sdt
Encs. [4]

B. A. Boyd, M.D., F.R.C.P.[C]
Medical Director

cc: Mr. L. C. Hales
Mr. L. A. Moricz ✓

Ministry of Health

Ontario

File No. [illegible]

Date August 11, 1975

Memorandum to

Dr. G. J. Maier
Unit Director
Social Therapy Unit - Oak Ridge

cc: Mr. L. A. Moricz
PAC Members

From

Dr. B. A. Boyd
Medical Director

Re Social Therapy Unit Treatment

Concern has been expressed by other Unit Directors and the Treatment Department Heads as to the direction of recent developments in treatment in the Social Therapy Unit. It is essential that you have support from this peer group.

The use of LSD as an experimental and research tool appears to be undergoing some change from the approach originally approved. I would ask that you not commit us to further LSD sessions beyond those presently approved until this situation is resolved.

The introduction of mystical concepts usually associated with oriental religions may well have just as much validity as some treatment modalities in current use in our society. They are difficult to assess scientifically and likely to be misunderstood and not accepted "politically".

I would ask you to gently de-escalate these aspects of your program unless you can muster more support from the Professional Advisory Committee, with the best interests of your patients' morale, and the long term welfare of the Social Therapy Unit in mind.

BAB/sdt

B. A. Boyd, M.D., F.R.C.P.[C]
Medical Director
[Acting Hospital Administrator]

Ontario

Date July 15th, 1976.

Memorandum to

Mr. P. M. Klamer,
Executive Assistant,
Psychiatric Hospitals Branch,
7th Floor, 7 Overlea Blvd.,
Don Mills, Ontario.
M4H 1A9.

From

L. A. Moricz, B.A.,M.H.A.
Administrator,
Mental Health Centre,Penetanguish

Re L.S.D. TREATMENT AT OAK RIDGE.

Please refer to the enclosed copy. Hopefully, it will be sufficient to supply you with data to answer the request of this "irresponsible" group.

L. A. Moricz, B.A.,M.H.A.
Administrator.

LAM:PII
Encl.

Form 86 — A5

Ontario Health

Date July 15, 1976

Memorandum to

Mr. L. A. Moricz

Administrator

From

Dr. B. A. Boyd

Medical Director

Re LSD Treatments at Oak Ridge

In regard to Mr. Klamer's memorandum of July 9th, I hope that the Scientologists [Citizens Commission on Human Rights] can be kept out of this question as much as possible.

The patients are very fully informed of the possible benefits and possible damage from this treatment and the treatment is carried out only with their full and informed consent. As they are incarcerated one would have to admit that there is an element of coercion as there is inevitably with any consent.

Dr. Barker several years ago described his program with LSD thoroughly in a brief paper and Dr. Maier is presently completing a paper of the work he has done to date. I think these papers should be reviewed by the scientific community, including our Professional Advisory Committee.

I am hopeful that the new Unit Director, whoever he may be, will be interested in continuing this program. From my observation it appears to have helped many patients and I have not been able to see any indication of harm from it.

BAB/sdt

B. A. Boyd, M.D., F.R.C.P.[C]
Medical Director

CITIZENS COMMISSION ON HUMAN RIGHTS

ONTARIO HEADQUARTERS
124 Avenue Road, Toronto. M5R 2H5
961-6301

Affiliated with the Committee on Institutional Psychiatry

Offices in: Vancouver
Ottawa
Montreal
Quebec
Regina
Winnipeg
Calgary
Toronto
Halifax

July 7,1976

Dear Mr. Klamer,

I am writing you to request some information concerning the LSD treatment used at the Oak Ridge section of Penetanguishine Mental Health Centre by Dr. Gary Maier.

The Citizens Commission on Human Rights, in the recent past, has contacted the Minister of Health enquiring about the nature of consent given by the patients at Oak Ridge who are undergoing this treatment. Our position on this matter is that, due to the possibility of adverse reactions to this drug, nothing less than fully informed consent should be obtained from any Oak Ridge patient who wishes to engage in this therapy.

I have recently heard that this treatment is going to be discontinued and I wish to verify this with the Ministry of Health. I wonder if you could write me a short note on the present status of the LSD program used at Oak Ridge.

Respectfully yours,

Peter Ramsay
A/Secretary,
Citizens Commission on
Human Rights,
Toronto

MENTAL HEALTH CENTRE PENETANGUISHENE
JUL 15 1976
RECEIVED
ADMINISTRATOR'S OFFICE

RECEIVED
JUL - 9 1976
PSYCHIATRIC HOSPITALS BRANCH

Ministry of Health

File No.

Date November 13, 1975

MEMORANDUM TO

Dr. B. A. Boyd

Medical Director

FROM

Dr. G. J. Maier

Director of Social Therapy

RE LSD

Today I talked at some length with Mr. Graham, who is the central person in charge of the licencing of LSD for clinical use in the Health Protection Branch of the Department of National Health and Welfare, (613-995-7818). Briefly he brought the following to my awareness. In 1969, when the legislation changed on controlled drugs, the licencing and purchase of LSD expired for Connaught Laboratories and was re-issued to the Health Protection Branch under Mr. Graham: Since 1970 then, his Branch has issued LSD to only three places in Canada: (1) In 1970 and 1974 they sent one hundred, one hundred microgram vials to Drs. Baker and Solursh at the Toronto Western Hospital. (2) In 1970 they also sent two hundred, one hundred microgram vials to Dr. Marjersson at the Research Unit, Department of Psychiatry, Universi Hospital, Saskatoon. (3) In October 1973 they sent two hundred, one hundred microgram vials to me.

In talking with Mr. Graham I pointed out that Dr. Barker has submitted a paper entitled ISD in a Coercive Milieu Therapy Program to the Canadian Psychiatric Association Journal. When the mails start I will be sending him that paper, plus copies of Penetang: People and Paradox which describes our programming and indicates that LSD has a place in our Social Therapy Unit. I also explained to him that two further papers with exhaustive bibliographies will be forthcoming, one hopefully before December and the other not before February 1976. For your information I have a rough draft of the first paper. I made Mr. Graham aware of some of the issues and the nature of our findings to date. He was interested and impressed. I made it clear that we would present the findings of our LSD research at the next appropriate scientific meeting either the Ontario Psychiatric Association or better the Canadian Psychiatric Association. I emphasized the desirability of "peer" review by our colleagues in psychiatry, in regard to both methodology and theory.

I also explained to Mr. Graham how our Professional Advisory Committee, Research Committee and Research Department were rightly involved in the issues which revolve around the clinical use of LSD here. He could well appreciate the political sensitivity that needs to be excercised in regard to this unique drug and even more particularly in regard to the "voluntary nature" of its administration. Further, I explained that it is my intention to contact Drs. Baker, Solursh, and Marjersson to compare notes and particularly with our Toronto colleagues, share information in regard to methodology and theory.

The possibility of receiving two hundred, one hundred microgram vials early in 1976 was raised and I found Mr. Graham compliant and enthusiastic in regard to further licencing our Mental Health Centre. I thought I should bring these issues to your attention.

GJM:lc

c.c. Mr. L.A. Moricz
Dr. V. Quinsey
Dr. M. Pruesse, Chairman of the Research Committee

G. J. Maier

Ministry of Health
Ontario

File No Dr. L. Moricz

Date August 11, 1975

Memorandum to

Dr. G. J. Maier
Unit Director
Social Therapy Unit - Oak Ridge

cc: Mr. L. A. Moricz
PAC Members

From

Dr. B. A. Boyd
Medical Director

Re Social Therapy Unit Treatment

Concern has been expressed by other Unit Directors and the Treatment Department Heads as to the direction of recent developments in treatment in the Social Therapy Unit. It is essential that you have support from this peer group.

The use of LSD as an experimental and research tool appears to be undergoing some change from the approach originally approved. I would ask that you not commit us to further LSD sessions beyond those presently approved until this situation is resolved.

The introduction of mystical concepts usually associated with oriental religions may well have just as much validity as some treatment modalities in current use in our society. They are difficult to assess scientifically and likely to be misunderstood and not accepted "politically".

I would ask you to gently de-escalate these aspects of your program unless you can muster more support from the Professional Advisory Committee, with the best interests of your patients' morale, and the long term welfare of the Social Therapy Unit in mind.

B. A. Boyd, M.D., F.R.C.P.[C]
Medical Director
[Acting Hospital Administrator]

BAB/sdt

File No. .....

Ministry of Health

Date July 24, 1975

MEMORANDUM TO

ALL MEMBERS OF THE PROFESSIONAL

ADVISORY COMMITTEE

FROM

Dr. G. J. Maier,

Director, Social Therapy Unit

RE F Ward Program - The Relationship Between Inner and Outer Space.

Enclosed please find a copy of the current reading list for the F Ward Program. These books are being read and discussed on F Ward and are the core of the theoretical/experiential discussion. As a member of the Professional Advisory Committee interested in the F Ward program, I wonder if you could advise me in regard to the following theoretical/practical areas.

(1) The comparison between the Tonal and Nagual states of reality as described by Castaneda in his four books, and their relationship to the existential world described by Sarte in his book Being and Nothing.
If there is a comparison what are the limits of this?
How do these states of reality relate to the Zen term "no mindedness"?

(2) If for simplicity sake an ecological view of reality implies cultural, personal and intrapersonal levels, how would the terms archetype, mandala, and symbol relate to uniting this reality view?

The phenomenology of LSD is very exciting. To understand these images, requires an understanding of the physiology of our senses, and even more than that it requires direct experience of these levels of reality within us. Our contention would be that every man can directly experience these inner bands of reality with a correspondance equal to the view of data traced on graph paper. Our contention would be that Eastern and Western science are engaged but the relationship has not been consumated. We would like to preside at the wedding.

GJM/lc

G. J. Maier

STU file

F WARD PROGRAM

READING LIST JULY 1975

1. I Ching - Legge
2. Chaung Tzo - Genius of the Absurd - Waltham
3. Embrace Tiger, Return to Mountain - Al Chung
4. Tai Chi for Health - Maisel
5. Tibetan Book of the Dead - Wentz
6. Psycho-Cybernetics Principals for Creative Living - Maltz
7. Zen Flesh, Zen Bones - Reps
8. Chuang Tzu Inner Chapters
9. Tao Te Ching
10. Practice of Zen - Chang
11. Stones, Bones and Skin
12. Zen and the Art of Motercycle Maintainance - Pirsig
13. The Bhagavad Gita - Bhaktivadanta

14. Yoga and Health - Yesvdian
15. The ABC of Yoga - Kareen Zebroff
16. Teachings of Don Juan - Castaneda
17. A Separate Reality - Castaneda
18. Journey to Ixtlan - Castaneda
19. Tales of Power - Castaneda
20. The Yoga System of Health - Vithaldas
21. Karma Yoga, Bhakti Yoga - Vivekananda
22. Raja Yoga - Vivekananda
23. Exec Yoga - Bahm

24. Maps of Consciousness
25. The Living Brain - Walter
26. The Doctor and the Soul - V. Frankl
27. Altered States of Consciousness - Tart
28. Venture Inward - Hugh Lyne Cayce
29. The Varieties of Psychedelic Experience - Masters and Housten
30. Flesh of the Gods - Furst
31. Master Game, The - De Ropp
32. Life Against Death - Brown
33. Wisdom of Insecurities - Watts
34. Gestalt Therapy Verbatim - Perls
35. Center of the Cyclone - Lilly
36. Psycho-Cybernetics - Maltz
37. Be Here Now - R. Alpert
38. Magister Ludi - Hesse
39. Varieties of Religious Experience - W. James
40. Hallucinogens and Shamenism - Harner
41. This Timeless Moment - Huxley
42. The Joyous Cosmology - Watts
43. Don't Push the River - Stevens
44. ISD, The Pritate Sea, and the Search for God - Braden
45. Soma - Devine Mushroom of Immortality - Wasson

continued.....

46. Sybil - Schreiber
47. Sanity, Madness and the Family - Laing and Esterson
48. Readings from Psychology Today - Edited by Magizing
49. New Horizons in Psychology - Foss
50. Social Class and Mental Illness - Hollinghead Redlich
51. I'm OK, You're OK - Harris M.D.
52. Psychotherapy, East-West - Watts
53. Man and His Symbols - Jung
54. Doors of Perception - Huxley
55. Ecology of Mind - Bateson
56. 78-187880 - Edited by Leary
57. Body Language - J. Fast
58. Exploring the Occult - D. Hunt
59. Story of Jesus - Cayce
60. The Prophet - Gibran
61. Myth of Mental Illness - Szasz
62. The Crown of Life - Singe
63. Jung - Edited by Campbell

24/7/75
lc

Ministry of Health

File No. .....

Date July 24th, 1975.

MEMORANDUM TO

Dr. B. A. Boyd,

Medical Director.

FROM

Mr. L. A. Moricz, B.A., M.H.A.

Administrator.

RE Dr. G. J. Maier.

CONFIDENTIAL.

In line with the unauthorized issue of the "F" Ward film by Mr. F. Loucks on the request of Dr. Maier, an informal hearing was held with the participation of Drs. Levinskas, Maier and myself. It was agreed that thorough investigation will be postponed until your return on duty. You are requested hereby to carry out the above hinted inquiry with regard to this matter. I rely on your advice.

Dr. Levinskas also felt that Dr. Maier's LSD program also needs a special looking into.

Needless to say, his general behaviour is not improving. Complaints are aired at all staff level. It is felt that both Oak Ridge staff and patient morale level's fluctuations are strongly affected by his mood variation and variation dictated action.

I think another good look will help us to make the necessary steps for an already limited change-over.

Yours truly,

L. A. Moricz, B.A., M.H.A.
Administrator.

LAM:PH

c.c. Dr. L. Levinskas,
Acting Medical Director.

Form 86 - 68-1570

OL 14

February 27, 1976

Mr. R. A. Graham,
Chief, Scientific Services,
Health Protection Branch,
National Health and Welfare,
Tunney's Pasture,
Ottawa, Ontario
K1A 0L2

Dear Mr. Graham:

Enclosed for your perusal are two copies of three different papers. I am sending these to you in regard to our use of LSD and as you will see from my memorandum to Dr. Boyd, I hope shortly to have a second paper outlining our further use of LSD, particularly in the last year.
(1) LSD in a Coercive Milieu Therapy Program, Barker and Buck, submitted for publication to the Canadian Psychiatric Association Journal
(2) Penetrance: People and Paradox, Maier and Hawke, to be submitted to the Canadian Psychiatric Association Journal
(3) memorandum to Dr. Boyd in regard to our telephone conversation of November 13th, 1975.

We were very pleased to have received permission from the Health Protection Branch to use LSD with patients in our Maximum Security Hospital. We hope in the future that you will continue to license the research at our hospital. These papers are our first offering to your Department upon which to build the basis of clear communication in regard to our responsible use of this unique drug. It is my hope that Dr. Silverman will accept the presentation of the "Ward LSD Program 1975" as part of the Canadian Psychiatric Association's program for the fall of 1976. A copy of that presentation will be forwarded for your perusal once it is completed. I think you will find these papers interesting and I am eagerly awaiting any comments that you have.

Yours truly,

G. J. Maier, M.D.
Director of Social Therapy

/lc
Encls.
c.c. Mr. Moricz

THE INSANE CRIMINAL AS THERAPIST

DR. E. T. BARKER
M. H. MASON

Reprinted from the October 1968 issue of **The Canadian Journal of Corrections**, Vol. 10, No. 4, published by the Canadian Corrections Association, 55 Parkdale Avenue, Ottawa 3, Ontario, Canada.

The Insane Criminal as Therapist

DR. E. T. BARKER
Assistant Superintendent
Penetang Psychiatric Hospital
Penetanguishene, Ontario

M. H. MASON
Patient
Oak Ridge Division
Penetang Psychiatric Hospital
Penetanguishene, Ontario

This paper will describe briefly the development of a sequence of complementary milieu therapy programs for mentally ill offenders in Oak Ridge, the Maximum Security Division of the Penetang Psychiatric Hospital, Penetanguishene. It up-dates an earlier account of a pilot project (Barker and Mason, 1968).

Comprising eight 38-bed wards, each lined with barred individual rooms and served by a complex of storage rooms and meeting space, this structurally-designed prison functions as a mental hospital, and admits patients in four main streams, serving in its various capacities the entire Province. The courts send male persons found unfit to stand trial or not guilty by reason of insanity, and others for thirty and sixty-day periods of assessment and observation, where their charges or instability are serious enough to rule out the use of a local psychiatric unit. From the federal Penitentiaries at Kingston and Stony Mountain, and the Ontario Department of Reform Institutions and jails, come those mentally ill inmates whom treatment facilities there are not equipped to help. From the other twenty-two mental hospitals serving the Province arrive elopers and persons too assaultive or destructive to be treated there.

Since the institution opened in 1933, the population has been composed of a fast-moving stream of patients who return to court, a slower-moving group who stay from a year to five years before a release is possible, and the balance who, because of the seriousness of their legal and psychiatric situations, do not expect to be released for ten, twenty, or thirty years. Most members of these last two groups are severely mentally ill, many not obviously so to the short-term observer, and few of them either recognize or agree to the fact of their illness.

It is tempting to view the superficially sane patient as more bad than mad, and much confusion may exist about the best way of viewing mental illness, even when it is agreed to be present (Siegler and Osmond, 1966). The approach adopted towards such patients in Oak Ridge's recent past has been to provide tranquillizers for many, E.C.T. for a few, and for all

a comfortable, but custodial, environment where progress is measured in amenities.

Our present point of view is that most people *can* benefit from more active types of treatment than tranquillizers, that the insane and dangerous criminal *must* if he is to be released, and the ordinary thug *ought to*, if it will decrease the crime rate.

Since, for the insane criminal, the alternative to successful treatment is lengthy incarceration, we have since 1965 been developing intensive social therapy programs aimed at compressing into a few intensive treatment years the presumed benefit of custodial decades. We have been doing this in the relative absence of professionally trained staff, and with an attendant staff which, by nature and nurture, is custodially-oriented. Since we are keenly aware that for many of our patients the first symptoms of a relapse may again be murder, rape or arson, our objective is a major reconstruction of the personality, as opposed to supportive or repressive measures. If we were not naively idealistic, we would not have begun the process at all, but now with it under way, the undertaking seems preferable to the defeatist inertia of comfortable custody in terms of the heightened morale of both staff and patients, and the increased safety of more informed assessments of the patients' readiness for release, to say nothing of the possibility of the freeing of healthy human potential.

It is thought that about half of the patients in Oak Ridge might benefit from this form of therapy, and in a two-year period, a five-unit treatment program has been developed which constitutes our Social Therapy Unit. Three 38-bed Encounter Therapy Units, one 22-bed Training Unit and one 16-bed Compressed Encounter Therapy Unit, are staffed by three Social Work Assistants with B.A.'s, one M.S.W. Social Worker, and a full complement of Attendants — three for morning and afternoon shifts, and one at night. In the first year, a psychiatrist worked full time, in the second year half-time, in the development of these programs.

A number of fundamental assumptions (discussed in detail elsewhere) guided their evolution (Barker and Mason, 1968).

The Major Assumptions

1. *Illness as the failure of communication*
   Whatever the causes of it, mental illness is felt to be the sum of the ways in which the patient is unable to relate satisfactorily either with himself or others.

2. *Dialogue as therapy*
   Genuine and spontaneous dialogue with others, as Buber defines it (Buber, 1961), is thought to be the substance and achievement of therapy. Once it is achieved, it seems to us

that the symptoms of illness will wither away, starved of the falsity that maintains them.

3. *The patient as agent of therapy*
   The shortage of professional staff, their shortcomings as therapists, and the existential equipment of patients to help one another, suggest that perhaps they should be the principal agents in their own treatment. Their shortcomings as therapists seem to be minimized by the reciprocal checks and balances that they can exert on one another in appropriate group settings.

4. *Total experience*
   It is a major assumption that as many hours of the day as possible should be used to help the patient change in a way that will end his confinement.

5. *The legitimacy of coercion*
   Where a patient is confined against his will until he changes his behaviour, it seems humane to use force at least to the point of increasing his awareness of himself and others so that, as far as can be determined, what he does, he consciously chooses to do.

Development I: The Pilot Project

Over a twelve-month period from September 1965 to September 1966 what later came to be called an Encounter Therapy Unit was developed on one of the wards in Oak Ridge (G Ward), starting from a foundation of a single Ward Council meeting every two weeks, and reaching peaks of ninety-hour a week programmed group activity. Patients were initially selected for the ward on the basis of verbal ability, and most were relatively young and intelligent psychopathic or schizophrenic offenders between 17 and 25. The program, described in detail elsewhere (Barker and Mason, 1968; Mason, 1967; Hollobon, 1967) was in a continuous state of change according to the perceived needs of the unit, but a formal social structure eventually emerged which is now common to all our structured milieu therapy programs.

Roles in work settings occupy about a third of the patient's day. For the remainder, he moves through an intensive series of committees and groups which place him in different settings with different role expectations. The units operate on an almost staffless basis that frees them from dependence on professional staff resources except for the use of medication. Confrontation and communication take place between patients at a relatively intense level. Patient committees generate, maintain and enforce participation in intensive and complex time-tables of ward

meetings, Small Groups*, and drug treatments, which have employed amytal-methedrine, tofranil-dexamyl, L.S.D.-25, and scopolamine-methedrine as forms of defence-disrupting therapy (Barker, Mason and Wilson, 1968). For two or three hours every day, meetings with all thirty-eight patients present discuss feedback from the five committees and five Small Groups that meet daily. Consistently, a mirroring and confronting approach is maintained which emphasizes individual illnesses as they appear in here-and-now situations. Repetition and sanction are employed to drive home to the patient the fact of his illness, and the means of overcoming it — the free and open expression of thoughts and feelings.

Because of the planned anxiety-arousal measures, some patients become homicidal or suicidal risks, and they are cared for by an elaborately organized security system (Barker, Mason and Walls, 1968), which keeps them in total participation under conditions of safety.

Formal contact is maintained with the staff by a Liaison Committee comprising four patients and the Ward Supervisor. Perhaps the most important structural characteristic of the patient committee system is the way it operates with little dependence on staff to initiate and sustain proceedings. Recommendations are made to them directly, and the Ward Supervisor maintains close contact with all developments, but in practice seldom has to exercise his unquestioned power to veto any committee decision. Staff are by decree not expected to become involved with patients in discussion or explanation of their own feelings or thoughts. Therapy is equated to open and honest dialogue, and is the business of the patients, not the staff — a distinction which has been found both necessary and advantageous in our setting.

After a twelve-month period, during which the remainder of the patient body in Oak Ridge became accustomed to the new concepts that were filtering out of the pilot Encounter Therapy Unit, and attendant staff no longer expected the daily collapse of the community into an Armageddon of violence and madness, growing enthusiasm on other wards seemed to signal their readiness for milieu therapy programs.

Development II: Expanding Operations

In an eight-month period, a Social Therapy Unit crystallized, with four units operating at various levels of intensity. These developed at different rates, reflecting the various populations of the wards, but the pattern of committees, "Small Groups" and ward meetings repeated itself in a way that supports a notion of its general applicability. With minor variations, programs have developed on three Encounter Therapy Units into a daily pattern of three hours' paid work in Industrial Therapy or

* A colloquial term for ad hoc staffless therapy groups for upset patients, thought to be the core of the programs.

school, four hours in intensive group inter-action, and four hours' evening recreation, which includes physical training, dances, sing-songs, and volunteer activities.

Development III: The Training Unit

At the beginning of treatment we find it helpful to attempt some modification of the rigid framework of subcultural paranoia that many patients bring to us from reformatory or penitentiary. Bright, tough and manipulative, these persons present a formidable threat to the principles of openness and communication on which our programs are based. Encounter Therapy Units do not seem well-adapted to receive such patients initially. It is difficult and time-consuming to convince the newly-admitted and well-defended psychopath, for example, of his sickness and need for treatment. With the aim of facilitating the process, a 22-bed Training Unit was established where new admissions to the Social Therapy Unit pass through a program of ward meetings, group discussions and lectures. Patient-prepared papers on communication, disruption, manipulation, defence mechanisms, logical fallacies and interpersonal behaviour, are discussed intensively; simple multiple-choice examinations are administered until it is clear that the individual has at least memorized the basic principles and assumptions of milieu therapy. Committees from other Encounter Therapy Units visit the Unit regularly to give first-hand accounts of their roles in their Units, and to look for patients who might be suitable for transfer to their particular wards.

The Unit is effectively directed by four patient "Trainers" who have experienced one or two years' intensive milieu therapy. Some of them have been in Department of Reform Institutions, talk the language and practice the skills, which they now use in support of the institution's goals. They are paid an hourly rate for their work, just as they would for any other Industrial Therapy assignment in the hospital.

The program has the dual objective of familiarizing new patients with milieu therapy, and socializing them to a point where they will be less of a problem to an Encounter Therapy Unit. Hopefully, also, they will grasp the eagerness of the administration to involve them in a mode of interaction which appears more valuable than swapping lies about past, or planned, anti-social acts.

The Limitations of Encounter Therapy Units

Three major trends seem to limit the value of Encounter Therapy Units. With disturbing persistence, some patients make "public" statements supporting whatever is currently believed to be approved by authority, and private statements of quite different content. The individual finds himself on occasion unable to express his true feelings either in public or

in private settings, and a triple division into public, friendship group, and intra-personal beliefs can occur.

Secondly, a trend towards excessive organization limits the capacity of the program to help slick and intelligent patients who can manipulate their way through the loopholes in an organized structure. In addition, those who can organize and direct the treatment methods of others are often *ipso facto* in a position where such efforts cannot reach them. Their already elusive pathologies are further obscured by a galaxy of bureaucratic duties, which they have no trouble in fulfilling. Their immaculate performance in the organization seems to make other patients unwilling and sometimes unable to identify their illnesses and treat them. In brief, some patients can play the therapy game and remain untouched by it.

Finally, although the observer system operates to reduce considerably the chances of suicide or homicide, it is only as effective as the insight of the patients and staff who attempt to spot the risks. When a certain level of group anxiety is reached in a setting where patients live in rooms with potential weapons like coffee jars (knives), sheets (ropes), and bedsteads (clubs), it becomes prudent to doubt the ability of even the best committee and staff to identify acting-out risks. Perhaps by acting on the assumption that it is best to be too careful, we have so far experienced no serious trouble in this area, but the possibility remains a constant concern.

Development IV: Questioning Assumptions and Eliminating Risks

To overcome these limitations on patients who realize that the safe intensity level on Encounter Therapy Units is not significantly affecting them, a Compressed Encounter Therapy Unit was established. After two months of exhaustive patient discussion, a program was conceived that seemed to meet the two most basic conditions: total safety from homicide and suicide, and total personal confrontation. It is rewardingly convenient that measures serving one of these goals almost without exception serve both.

The Compressed Encounter Therapy Unit housing this program is entered by a grill gate, and comprises one large room about four yards by twenty, a smaller room with open toilets and washbasins, and a shower room without partitions. Except for such things as dental or X-ray work, no patient leaves this area, and when he does he is very closely observed. All windows are screened, all electric outlets and lights protected. Meals are served on paper plates and cups, and eaten in the unit. Except for their cushions, mattresses, uniform khaki clothes, toothbrushes, towels and soap, there are no other objects in the unit. No chairs, shoes, books, television, radio — nothing. Every patient is always in the presence of at least three others, and for the overwhelming majority of the time, the entire group. No room used by the patients has a door on it. All sleep

together in a large, brightly-lit room at night, where close observation is kept by an attendant, two patient observers who stay alert on dexedrine, and a closed-circuit television camera. There is nothing to do except to talk to one's peers, or keep silent and think, withdrawal being reduced to psychological privacy. Mail and visits are discouraged as outlets into fantasy, away from the here-and-now.

While a list of these measures reads like unabashed barbarism or perverted economy, they guarantee as far as possible the safety of patients to confront the genuine emotions in one another without undue concern for homicide or suicide. In some ways, this program resembles Marathon T-Group sessions which have been developed for relatively "normal" persons to run continuously for several days (Bach, 1964). Until the value of this program (which began in October 1967) is better established, it is felt desirable to include only volunteer patients. Since many who are convinced of the gravity of their legal and psychiatric situations are keen to participate in any program that might free them from their illness and hence from the hospital, this presents no problems. Of the first group of sixteen patients, which remained in the unit for four months, eleven had experienced at least a year of highly organized milieu therapy prior to their Compressed Encounter Therapy. Fourteen of them fell into the 18-30 age group, and all were of average or bright intelligence, with a range of education from Grade 7 to some university. Eight were diagnosed Personality and Character Disorders on admission, eight suffered from schizophrenic types of disorder. Fourteen were charged with criminal offences, seven with capital murder, one with rape, one with attempted murder, and the remainder with less startling offences, like possession of a deadly weapon, assault, armed robbery, and theft.

Human Relations Training literature and other papers thought likely to stimulate non-dogmatic exchanges are introduced and exhaustively discussed as a step towards undermining the systems of beliefs about health and illness that are felt likely to block treatment in this special setting. The sole administrative instrument of patient action is the total community meeting, which makes all recommendations for defence-disrupting medication, and performs all the functions that on other units are delegated to a complex bureaucracy of committees. Scopolamine and methedrine are administered to at least four patients each week, as measures to focus group activity, reduce individual defences, and hasten confrontation. Since all members of the community now live in one anothers' presence, it is no longer necessary to employ elaborate observation procedures, and patients who are medicated wander quite freely. Tranquillizers are never used, even in cases where patients become "psychotic". We conclude with Laing (1967) that intervention in the process of a phychosis may often frustrate or interrupt an innately helpful series of events. Sustained and genuine concern, plus the elimination of physical danger, seem preferable to chemicals or electricity, when such a milieu can be established.

Attendant Staff

Each ward is staffed by a permanent supervisor and two other attendants, who frequently change from ward to ward. The attendants' norms of strict adherence to working hours, the job specifications requiring two staff members "observing" on the ward and one at the front, and the high cost of overtime pay, all combined to create a situation where the changes described in this paper have taken place without having formal meetings or discussion groups with attendant staff, although informal communications between a few key attendants and professional staff occur frequently on a one-to-one basis.

Early in the process of change, attendants developed anxieties about the disorder and madness that might be unleashed in a move towards more active treatment. A tactical device of great value in smoothing the passage of innovations was the practice of making no move that diminished security. Perhaps surprisingly, this did not interfere with the intensity of interaction in the hospital and, reassuring the staff that their primary role function as they saw it was not being weakened, helped gain their support. Consistently backing all changes was the innovators' total control of line authority, which was recognized universally, but only tactfully and rarely exercised.

Senior attendant staff play a key role in the operation of all units, legitimizing and monitoring all patient action. Their support of, and belief in, actual treatment goals is less important than their support of the mechanisms used to achieve them. Overt opposition may be taken account of and allowed for administratively. Supervisors whose attitudes are basically custodial, but tolerant of patient committees, can and do make positive contributions. Supervisors who choose to *covertly* undermine changes can act as a formidable brake on development.

Relevance of the Program

On a foundation of no special staff training or hiring, active programs involving 150 patients have been established. On the surface, it seems obvious to us that our patients are at least more usefully occupied and happier now than when they lounged through a perpetual coffee break, colluding in one anothers' fantasies, or busied themselves with statistically impressive Industrial Therapy programs, which lighten confinement and appease the public, but leave pathology intact. An objective comparison study with follow-up has been initiated to assess the effects of this type of program on recidivism rates.

We see ourselves offering little of value either to the first offender, who is very often unlikely to repeat after a stay in the existing Department of Reforms Institutions facilities, or to the offender who, after a long series of incarcerations, is probably beyond the help of any treatment. Our

efforts may be relevant to the persons falling between these two categories, too ill for supportive or repressive measures, but still amenable to therapeutically-organized programs using one another as therapists.

Summary

The Social Therapy Unit of the Penetang Psychiatric Hospital offers three types of milieu therapy programs to 150 patients, most of whom have been charged with criminal offences. After a sketch of the development of these programs in this previously custodially-oriented institution, which operates with a minimum of professional staff, the structure and operation of each type is described. The 22-bed Training Unit familiarizes patients with milieu therapy concepts, using a didactic approach. This is a prelude to the patient's entry into one of the three, 38-bed Encounter Therapy Units, where almost autonomous patient committees organize group-oriented treatment programs. A Compressed Encounter Therapy Unit of sixteen beds offers unique conditions of maximum confrontation and maximum protection from the risks of homicide and suicide that accompany high intensity treatment in this institution.

Evaluative research is being initiated in conjunction with the Ontario Department of Reform Institutions to compare the effects of this hospital milieu with that of a reformatory on young offenders who are likely to repeat.

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PROTECTIVE PAIRINGS IN TREATMENT MILIEUX:

HANDCUFFS FOR MENTAL PATIENTS

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In an age when progress in the care and treatment of the mentally ill has been measurable in terms of increased freedom from physical restraints, it is paradoxical to say the least, that we find ourselves in one section of the Ontario Hospital Penetanguishene using handcuffs as a valuable aid in an intensive treatment program.

Patients are sent to "Oak Ridge", the 300-bed maximum security division of the Ontario Hospital, Penetanguishene, from the courts, reformatories, and other Ontario Hospitals. Generally, they constitute a group that cannot be safely treated elsewhere because of the seriousness of their legal and psychiatric situations. The expectation is that they will be detained at Oak Ridge until they change in a way that reduces to a minimum the chances of their manifesting again the symptoms that made them dangerous to society. In 1965, treatment programmes described in detail elsewhere (1,2,4,5) began a process aimed at providing some of these patients with an experience that might enable them in a few years to make the changes that were formerly thought to take place over decades in the absence of active treatment.

Although most patients viewed with reluctance the prospect of rigorous and anxiety-producing treatment, many were well enough to appreciate the improved chances of release that it might offer. Thus, within a relatively short period, it was possible to establish programmes of intensive group interaction, involving entire wards for many hours each week, and involving the administration of defence-disrupting drugs like scopolamine and methedrine (3). In such settings, the aroused anxieties and emotions of patients, thought to be a desirable and necessary phase of shorter

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term treatment, also created higher risks of homicide or suicide.

Traditional approaches attempt to guarantee the safety of the distraught patient in various ways. He can be chemically protected by tranquillizers, given electro-convulsive therapy, physically protected in a safe room stripped of all potential weapons, or be removed from the situation that is causing his anxiety. However, while these methods make it less likely that the patient will harm himself or others, they have the disadvantage of removing him from continued contact with his peers and the staff, or in other ways cutting short a process of anxiety-arousal that might be a major contribution to solving the patient's conflicts if allowed to progress safely.

Extended discussion of this obstacle was common in the pilot treatment unit, but no alternatives were found to the traditional methods until it was proposed by a schizophrenic who had murdered three persons that the best way he could see of protecting someone from his own anxiety was to have someone else with him all the time. He suggested to his skeptical peers at a ward meeting that this could be simply achieved by joining them with a locked strap at the wrists. This solution had all the strangeness of simplicity and initially provoked criticisms that it was barbarous and a police measure. After a while, however, the advantages of protection and interaction involved in the device became clearer, and it was implemented.

Patients designed a strap about 18 inches long made of car seat-belt material, with a series of grommeted holes along the centre of it. When used with two small padlocks, this strap becomes a durable handcuff. Thus, by a simple arrangement of patients and shifts, each potentially

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homicidal or suicidal patient is constantly in the presence of another patient who is better-integrated and responsible for seeing that he does not harm himself or anyone else. A complex set of norms has been developed on the wards, offering milieu therapy, which places a high value on conscientious duty as an "observer". During the day, each observer, who is selected by a patient committee and approved by staff, works a four-hour shift.

The ostensible barbarism of procedures which involve direct physical restraint can often obscure their advantages in therapy, clouding the perhaps greater but less obtrusive violence of chemical, electrical, and architectural restraints.

That they effectively reduce the risks of homicide and suicide is, of course, the major justification for handcuffs, but other advantages disive from their employment. The patient is continuously in the presence of his friends and enemies, no matter what he does, an arrangement which builds a powerful and unavoidable bond between the individual and his group. Regardless of the degree of upset, he can remain in a group of his peers to talk (or shout) about his feelings if he wishes. He remains mobile, may participate in all activities, and may feel better at having been cared for by his peers rather than by staff, gaining perhaps some ego-enhancement from the attention. Patient committees are aware of the potential value of the intense interaction experienced by someone joined to others for sixteen hours a day, and when assigning observers make tactical use of the patient's enemies and friends in an effort to facilitate helpful encounters. Like the observee, the observer suffers the temporary discomforts of the cuffs, and although the anxiety aroused by observing can sometimes be acute, its resol-

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ution can be valuable. Moreover, the observer derives the satisfaction of being obviously the treator in a helping relationship, officially confirmed in a position of physical and emotional responsibility - a useful and often new experience for many patients.

In short, the development and elaboration of systems of safe observation permitted Oak Ridge units to develop their programmes to an intensity that would have been impossible with the use of traditional methods. Application of the usual safeguards would have worked against the intense group interaction which forms the basis of our "Encounter Therapy" programmes, and the employment of sufficient staff to do as effective a job of observing would be enormously expensive. The flexible use of handcuffs and observers in our setting seems to offer numerous direct and derived benefits, as outlined above, resulting in increased safety, increased responsibility, and increased involvement for patients.

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DEFENCE-DISRUPTING THERAPY*

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Introduction

At the Oak Ridge Division (Maximum Security) of the Penetang Psychiatric Hospital we are attempting to treat severely sick persons whose legal and psychiatric situations could hardly be worse. Many patients are admitted after having been charged with serious offences and found unfit to stand trial, or not guilty by reason of insanity. Where the past record and present dynamics suggest – and very often they do with Oak Ridge patients – that murder, assault or arson will be likely to accompany the early stages of a subsequent relapse, their management revolves around the mandate that they are not to be released until they are no more likely to burst into violence than members of the general public.

Traditionally, society's processes have confined such persons for an indefinite period, with the primary emphasis on the protection of society by a very long period of segregation. Administrative efforts have been maintenance-oriented, using the traditional psychiatric measures of tranquillizers and E.C.T., and measuring progress by the accumulation of amenities, such as radios, T.V., movies, sports and volunteer programs.

Patients who are well enough to realize the seriousness of their situation are at least intellectually keen to volunteer for rigorous programs which might free them from the tyranny of their illnesses – and consequently from incarceration–in a shorter time. Largely because of this we have been able to organize 'Encounter Therapy Units' which encourage, develop and depend on the skills of patients in treating each other – a resource not easily tapped except in 'long stay' hospitals, which are chronically understaffed. These treatment methods have been described in detail elsewhere (2, 3, 7, 8) but a particularly complex challenge to the resources of the therapeutic community is presented by the patient who enters the hospital with a relatively calm exterior and an abundance of social graces, enabling him to convince himself and other patients that 'he needs no treatment'. While 'obviously psychotic' patients are often sent to us, we find that a majority of serious offenders carry a façade of plausible sanity. These persons are seriously ill in a special way, and we think that for such a person to have the intense chaos of his disturbance made more obviously apparent, both to himself and to others, has clear treatment advantages. We are therefore starting to use treatment methods geared towards exposing the shape and depth of the illnesses which many of our patients carefully conceal.

Two years ago we began by using amytal-methedrine, dextro-amphetamine imipramine,† and LSD-25, but have found that in our setting the joint use of scopolamine and methedrine is probably of greatest value in loosening the rigidly implanted patterns of behaviour behind which many patients hide the turmoil of their disorders. This paper describes our experience in the administration of about 1,000 doses of scopolamine-methedrine to physically healthy young males over a period of two years, a treatment method labelled DDT by the patients (Defence-Disrupting Therapy). Only patients who volunteer receive DDT. The treatment method has now gained such high status among the patients that requests for it exceed our capacity to give the drugs.

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†Dexamyl/Tofranil.

The Drugs

Both scopolamine and methedrine have been used separately to assist in uncovering hidden information. The term 'truth serum' was coined by Calvin Goddard in 1932 in connection with scopolamine, and our experience with it has tended to support the notion that it does not necessarily elicit the truth. The drug has been the subject of much criminological investigation concerning pharmacological effects (10). There has also been considerable dispute over its use by police agencies as a means of getting confessions, and the Cens case (10) is an outstanding example of the ramifications surrounding the employment of the so-called 'truth sera'. Goodman and Gilman (5) note that "scopolamine in therapeutic doses normally causes drowsiness, euphoria, amnesia, fatigue, and dreamless sleep. However, the same doses occasionally cause excitement, restlessness, hallucinations or delirium instead". Goldner and Forrer (6) stated that scopolamine is one of the drugs which alters ". . . the state of consciousness of an individual so that otherwise protected information is released upon questioning." They concluded that, used alone, scopolamine was only of limited value in releasing repressed material.

Methedrine receives glowing endorsement from Sargant and Slater (11) who state that doses of 10-20 mg. IV will abolish inhibitions and allow underlying thought processes and preoccupations to appear. The flow of talk is increased, while consciousness remains clear, and they consider IV methedrine to be the drug of choice for working over problems in the past and present life of the individual.

Methedrine also produces the secondary effect of sleep deprivation, and although our review of the medical literature does not indicate any specific therapeutic value in this, Bach (1) has attested to the value of sleeplessness in group interactions, commenting that "exhaustion and fatigue . . . lead to refusal to expend any energy on 'acting up' or 'acting out'. Tired people tend to be truthful. They do not have the energy to 'play games'."

The Supporting Culture

The orientation of our Encounter Therapy Units led to the development of an elaborate system for observing and protecting suicidal and homicidal patients. Norms which have been heavily reinforced since the beginning of these therapeutic programs make for the effectiveness and security of this system, since it has become more and more accepted as time goes on that each member of the community is in a very real sense his 'brother's keeper'. Disturbed patients on these wards are observed closely and conscientiously by their fellow patients, and if necessary are secured during the daytime by a locked canvas wrist strap (4) attached to the wrist of unmedicated patients, who observe him in four-hour shifts for as long as is necessary. At night a disturbed patient sleeps in a 'safe room' with two others who are responsible for his welfare. These arrangements not only give the usual advantages of peer group supervision but make DDT economically feasible; for the cost of traditional methods of hiring sufficient staff to observe highly disturbed patients would be out of the question. Moreover, ward staff are released from immediate involvement and can act in a supervisory role and as a flexible back-up resource.

Administration

Initially the drugs were administered in a variety of ways, and to some extent still are. At first we began by giving 1/75 gr. scopolamine and 15 mg. methedrine I.M. at 3:00 p.m., followed by 1/75 gr. scopolamine and 30 mg. methedrine I.M. at 7:00 p.m. For some time we alternated scopolamine and methedrine injections hourly for four to six hours. More recently, we have been giving scopolamine gr 1/75 I.M. q.l.h. until delirium (usually

three doses), starting in the morning, then 15 or 30 mg. methedrine I.M. in the afternoon if the patient seemed willing and able to talk with others, and followed by one or two dexedrine spanules at night.

Whichever the method of daily administration, the pattern is repeated for three or four successive days. All injections are given I.M., not only because it is felt to be safer in terms of slower peak effects on heart rate compared with IV administration, but also because this procedure eliminates the immediate dependency on a physician.

The Consequences: Physiological

The group of patients taking these drugs range in age from 17 to 25 and are in excellent physical condition. Both drugs raise heart rate and blood pressure but by different mechanisms, and for a time we used 30 mg. propivane by mouth to counteract the effects of scopolamine on the heart rate. We find that the pulse rate usually rises by the fourth day to a rate of 140-160 when the patient is standing, and it is suspected that this and the occasional hyperventilating and vomiting that occur are mostly due to the extreme anxiety evoked. There is always a reduction in the patient's appetite and he eats little during the period of administration. Sleeping is curtailed or eliminated completely.

Each patient is assigned a patient observer who is responsible for taking care of him, bringing food to him if necessary and completing a form which is subsequently passed to the ward physician, giving resting and standing pulses at periods of half an hour, one hour, and three hours after administration, as well as details of food and fluid intake and physical and psychological signs and symptoms. There is a doctor on call at all times but we have never had any medical 'emergencies' associated with the administration of these drugs.

Consequences: Psychological

The patient experiences drowsiness, fatigue and disinterest in his surroundings, interspersed with delirious episodes which are accompanied by hallucinations and floridly 'psychotic' behaviour. Contact with 'reality' is highly irregular and recall of events is patchy, the main presenting feature being a general lack of pattern to the sequence of experience and behaviour. Considerable paranoia is exhibited by most patients and the content of their delusions sometimes throws valuable light on underlying dynamic processes. Most of these experiences disappear within twenty-four hours of the final injection.

However, what seem to be the most useful effects occur during the weeks after drug administration, which appears to be a defence-readjustment period. It has been found that patients experience more anxiety for periods of up to two months following the termination of treatment. They seem less well defended, more sensitive, restless and troubled, undergoing changes of behaviour in which they frequently turn to their peers for support. Needless to say, for our polished, confident but insightless psychopaths and schizophrenics, such an experience appears to spur them to examine their assumptions about themselves and the world. Our experience suggests that subsequent courses of DDT increase the degree and duration of the anxiety experienced. We think also that the more prolonged and complete the period of delirium, the more are these delayed effects displayed. The defence readjustment periods warrant a research evaluation to find out whether they are a function of expectation, the *milieu* or physiological factors. It is possible that the drug-induced random experiencing of events and nullified interpersonal sanctions represent a partial desocialization process, more useful than simple retraining as a prelude to resocialization. (9).

Consequences: The potent disruptor

We have also found that scopolamine and methedrine may be employed to control patient behaviour which is massively and dangerously disruptive to the treatment *milieu*. Patients who have a solid background of introduction in the norms of a reform institution inmate subculture tend to undermine subtly or attack violently the principles of free communication upon which the therapeutic community depends, and their persuasive glibness or numbing hostility is profitably fragmented by DDT. As a rule they emerge from the experience with their aggressiveness considerably diluted. What is more they are also anxious and therefore considerably more accessible to treatment than had they been managed with large doses of a tranquillizer or seclusion, both of which have the two-fold disadvantage of making them a management problem and halting their involvement in the program.

DDT also gives a marked advantage to the psychopath who in our treatment setting must continue to live with the same group of people after they get 'on' to him. When forced to continue living with the same persons the initial attractiveness of these patients sours quickly to an acid savagery that wards off potentially helpful encounters. Most patients find it is easier to develop concern for the psychopath when he is chemically cooled out and dependent, than when he is 'normal' and coldly aloof.

Consequences: For the group

A major effect of DDT is its dramatic exposure of obviously abnormal behaviour to the patient and attendant groups. Ordinarily the behaviour of most patients in our Encounter Therapy Units is superficially sane enough, so that without these trenchant reminders both patients and staff run the risk of being lulled into forgetfulness of the underlying chaos. The patients frequently fall into this trap, solemnly substantiating their requests for release with the uneventfulness of their previous year in hospital.

The immediately obvious 'insanity' of the patient on scopolamine-methedrine also defines unmedicated patients in clear helping roles. Close bonds of responsibility and affection are sometimes developed between the 'sane' patient therapists and the chemically 'insane' patients. At times when four patients in the same unit are receiving the drugs simultaneously, every member of the unit is involved in immediate physical interaction with one of them. It seems that much of the value of DDT lies in the active participation of patients in the process of caring for one another, in the same way as has been suggested of insulin coma therapy.

Summary

Although its exact effects are uncertain and the best patterns of dosage and frequency have yet to be ascertained, a combination of scopolamine and methedrine given intramuscularly appears to have some value as a means of rendering young, physically healthy, mentally ill offenders more accessible to treatment when they are participating in an intensive therapeutic community program. It offers a form of control of the psychopathic patient which is superior to heavy doses of tranquillizers or seclusion. In all phases of its employment its effects on the group seem cohesive, providing a focus for concerned and helpful activities.

Addendum

The author has increasing reservations about the wisdom of publishing this paper. On the one hand, since it describes a rather radical procedure in steady use for some time it should be brought to the attention of the scientific community, but on the other hand the misuse of these drugs could be harmful in situations where the stakes are not so high as they seem to be for those incarcerated as 'criminally insane'.

E.T.B. May '69.

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Résumé

Bien qu'on n'en connaisse pas encore exactement les effets précis et que les meilleurs modes de posologie et de fréquence restent à déterminer, une combinaison de scopolamine et de méthédrine en injection intra-musculaire semble avoir une certaine valeur quand il s'agit de rendre des délinquants, jeunes, physiquement bien portants mais atteints de maladie mentale, plus accessibles au traitement lorsqu'ils participent à un programme intensif de thérapeutique communautaire. Cela permet de maîtriser le psychopathe mieux encore que des doses massives de tranquillisants ou que la séclusion. Dans toutes les phases de son emploi, ses effets sur le groupe semblent cohésifs et permettent de faire converger les activités sur un but intéressé et utile.

The race of mankind would perish did they cease to aid each other.
We cannot exist without mutual help.
All therefore that need aid have a right to ask it from their fellow-men; and no one who has the power of granting can refuse without guilt.

Sir Walter Scott
1771-1832

BUBER BEHIND BARS*

E. T. BARKER, M.D.[1] and M. H. MASON[2]

Introduction

This paper will attempt to describe some aspects of an intensive treatment program presently operating in an institution for mentally ill persons. The patients there are confined by law, against their will, until they change. Most of them stand to be confined for long periods of time; most of them do not feel themselves to be mentally ill; most of them do not agree that they need treatment.

The Setting:

The Ontario Hospital Penetanguishene is one of twenty-three similar institutions maintained in the Province by the Department of Health. It is distinguished from the rest chiefly by the presence of Oak Ridge, an administratively integrated but structurally separate division of the hospital. A maximum security building of eight 38-bed wards, it looks like and is built like a prison. Each ward has individual rooms ranging down both sides of a long corridor which debouches into a euphemistic sunroom capable of seating all ward members. Each room, with its bed, sink and toilet, is completely open to the corridor through the bars that form its front wall and door. There is no privacy.

Patients are referred to the Oak Ridge Division in roughly equal proportions from three sources: the courts, reformatories and penitentiary, and other Ontario Hospitals. From the courts come those found not guilty by reason of insanity, those found unfit to stand trial, and those remanded for thirty and sixty-day periods of observation. Reformatories and other Ontario Hospitals send those with whom their own facilities of treatment and security are insufficient to cope. Patients at Oak Ridge therefore vary widely in their legal classifications, some being seriously involved with the law, some not at all. Almost all were sent, and are being held, against their will.

In September 1965 it was decided to develop one of the Oak Ridge wards into an Intensive Treatment Unit, with the hope that the methods evolved there might eventually be used on some other wards as well. Our object was not so much to realize any preconceived psychiatric theory, as to mould a flexible and experimental approach around a few very basic assumptions.

The Major Assumptions:

1) *Sickness as the failure of communication*

The first, and perhaps most basic assumption underlying our program, was that sickness was essentially an inability to communicate. It consisted of the ways in which the patient was unable to relate either with himself or with others. We saw genuine communication as an end in itself, and each patient as one in some way unable to enter into dialogue with others. The fundamental parameters of illness as inability to communicate were thought to be well illustrated by Buber, when he speaks of

> ". . . monologue disguised as dialogue, in which two or more men, meeting in space, speak each with himself in strangely tortuous and circuitous ways, and yet imagine that they have escaped the torment of being thrown back on their own resources . . . A debate in which the thoughts are not expressed in the way in which they existed in the mind, but in the speaking are so pointed that they may strike home in the sharpest way, and moreover without the men that are being spoken to being regarded in any way present as persons; a conversation,

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characterized by the need neither to communicate something, nor to learn something, nor to influence someone, nor to come into connection with someone, but solely by the desire to have one's own self-reliance confirmed by marking the impression that is made, or if it has become unsteady, to have it strengthened; a **friendly chat,** in which each regards himself as absolute and legitimate, and the other as illegitimate and questionable; a **lovers' talk,** in which both partners alike enjoy their own glorious soul and their precious experience – what an underworld of faceless spectres of dialogue!" (3).

Of course, in equating illness with an inability to communicate, a criterion was established by which the entire population of Canada was moderately crazy. Nor did we wish to imply that there was little wrong with Oak Ridge patients. Far from that, these men had in many cases been certified mentally ill because they were exceedingly dangerous. There were a dozen killers on the ward where it was planned to develop the program. However, it seemed to be evident that phenomenologically illness resulted in a breaking down of communication, or was such a breakdown; and that therapy would involve re-establishing or strengthening the dialogue between the patient and others.

2) *Dialogue as Therapy*

We felt with Laing (11) that psychotherapy

"consists in the paring away of all that stands between us, the props, masks, roles, lies, defences, anxieties, projections and introjections, in short, all the carry-overs from the past, transference and counter-transference, that we use by habit and collusion, wittingly or unwittingly, as our currency for relationships. It is this currency, these very media, that re-create and intensify the conditions of alienation that originally occasioned them."

Perhaps psychotherapy is nothing but "an obstinate attempt of two people to recover the wholeness of being human through the relationship between them" (11). This is the primary experience, and it seemed to us that once this was achieved, the symptoms surrounding the self would wither away, useless. In Buber's terms,

"Each of us is encased in an armour, which we soon . . . no longer notice. There are moments which penetrate it, and stir the soul to sensibility. And when such a moment has imposed itself upon us, and we then take notice, and ask ourselves, 'Has anything in particular taken place? Was it not of the kind that I meet every day?', then we may reply to ourselves, 'Nothing in particular, indeed it is like this every day, only we are not there every day'" (3).

We felt that what might generally appear to be an idealistic approach to illness was realistic in a setting where patients were confined for very long periods of time. The time, and if administrative measures were taken, the space and opportunity, existed for patients to open themselves to the genuine dialogue that lies around them *in potentia* every day.

The terms of such a dialogue are, to paraphrase Seeley (13), a number of complex simplicities: simplicities of relation, focus, value, process and product. The relation is one which joins the parties to it in perhaps the greatest intimacy combined with the greatest distance that is in the compass of human experience. One patient must stand close enough to another to be his friend, far enough away to see what is happening. The focus is upon making what is unconscious, conscious. This is a two-way street, a process of mutual education. What each patient discovers of himself to his companion is part of his contribution; what he discovers of his companion to his companion is the other half. The paramount and only necessary joining value on both sides is the pursuit of truth, and the process is the continuous examination of the world as it is mirrored and distorted in the self, and the self as it is projected and distorted in the world. As Seeley concludes, "The product is, at a minimum, two people who know more about each other, each about the world, and each about himself. That is all. Perhaps, it is enough."

3) *The patient as agent of therapy*

The third assumption was that as far as possible professional staff would not be used in the program, but rather that the patients themselves would be the principal agents of therapy. As long as there are large numbers of patients and small numbers of professed experts, it is futile to develop any new techniques which are to depend heavily on staff for their success. Further, a program of treatment based on patients rather than staff lends itself to employment in other than hospital settings: reformatories, penitentiaries, training schools, or, in a modified form, in schools and universities, where one can never get 'enough' staff and where the inmates and students possess all that is necessary to create and sustain their program, provided that the correct administrative moves are made.

More importantly, another reason concerned the involvement of the professional in treatment. While it is true that psychiatrists, psychologists and social workers devote many years to accumulating a great deal of information about, and experience in the treatment of the mentally ill patient, there is some doubt about the efficacy of this training in making them therapists. It may sometimes increase the distance between them and their patients. It may sometimes be unaccompanied by the great indefinables of therapy: congruence, empathy, openness, the ability to encounter, call them what you will.

The obstacles to communication are doubled when, in settings such as Oak Ridge, the psychiatrist is in direct control of the liberty of the patient. It is unfortunate but true that this control of the patient's liberty is more or less sick, as the psychiatrist himself is more or less sick. Professionals do not often enough seriously maintain the habit of considering the ways in which their own sicknesses are barriers to the treatment of their patients. This is particularly true of those working in institutions which provide roles of power and security, for the role system seems to guarantee that few of them will think of themselves as 'equal to' the patient in any other than a diffuse philosophical-humanistic sense. The more ill-trained or inexperienced or maladjusted he is, the more will his role magnify those defects. The more he is in direct authority, or is seen to be, the more of a problem his sickness becomes (5).

Quite apart from the foregoing, however, it would appear that the patient is in many ways better equipped than the professional for a direct, helpful encounter. For one thing, he lives with his 'patient' for 24 hours a day, works, eats and enjoys recreation with him. For another, he is immediate to his 'patient', has no power over him, and is much closer to his mode of experience than any professional. And finally, he is 'committed' to a parallel experience in a way that no professional therapist can ever be. It is for him, in a real sense, a way of life, and he has no status or role to lose in the encounter. True, he is sick; true, he may be disturbed, disoriented, or immature. But he is human and unmagical.

What perhaps may reassure those unaccustomed to thinking in these terms is the fact that the short-comings of patient therapists tend to be ruled out in groups, where pathologies cancel and reciprocate one another. To give a very crude example, a schizophrenic will object to the slick solution to a problem adeptly flashed out by a psychopath. The psychopath will point with some justice to the woolliness and diffuse idealism of the schizophrenic. Or again, no one can so unerringly highlight the subtle manipulations of a severely sick psychopath as one who is similarly crazy. No one can perceive the first crumblings of a schizophrenic disintegration more quickly than one who has once similarly collapsed himself.

In short then, it was a major assumption in the development of our community that genuine encounter between patients could be therapeutic, and the role of the professional was cast as an ancillary one: to use his administrative power to set up the space for such encounters, and mould their terms towards dialogue.

4) *Total experience*

Another major assumption in structuring the program was that as many hours of the day should be used as was possible. The Oak Ridge patient is confined against his will because of certain aspects of his behaviour which are seen by society to warrant detaining him until he changes them. This lays some obligation on the hospital staff to help the patient to change the patterns of thinking and behaviour that prevent his release, and to do so as quickly as possible.

If it is desired to change behaviour, then, to take an extreme example, it is a gross waste of the patient's time to provide him with a milieu that reinforces illness for 23 hours of the day, and then attempt in perhaps one hour of the day some sort of experience aimed at reversing the process. Ideally, the patient should be allowed no experience that does not in some way contribute to his getting well, and every minute of his stay ought to be designed intentionally to bring about recovery and release. Even though the best means to this goal may not be known, maximal use should be made of those techniques currently thought to be helpful.

There is some question about how far a person who is not a patient can commit himself to a treatment of this sort. It is perhaps unrealistic to expect those cast in 'sane' roles to attempt to involve themselves at all in a total-experience, 24-hour form of therapy. Perhaps they cannot live in 'the world' and 'the treatment community' at the same time. Many factors seem involved. For one thing, it is hard for staff on an eight-hour shift to 'know' what is going on, the way permanent members do. Again, there often arises a barrier between those who can leave and those who must stay. 'Well adjusted' staff have little motivation to participate equally and fully in an anxiety-provoking situation, likely to produce change. Another factor is the fact that many staff have very immediate pressures on them from family or community or professional obligations — pressures that are very close and real but beyond the patients' sphere of involvement. There are accounts in the literature (8) of communities which ran into great difficulty because of the pressures placed on staff members who attempted what may be an impossible 'double life'. Perhaps they should either enter the treatment program as a fully participating member, or stay out of it and practice administrative therapy, leaving to others the business of direct encounter.

5) *Coercion and the goad to freedom*

To make the statement that patients should not be allowed any unhelpful experience is of course to stumble into the thorny question of coercion and non-acceptance. Those who feel, with Carl Rogers (12), that even to evaluate is to corrupt the helping relationship, might object to suggestions that to use force — is to make such a relationship possible; that to repeatedly and without compromise thrust a person's illness before his eyes — is to sustain such a relationship; that to insist upon a person's examining his own behaviour — is to make him free. Approaches of that sort seem to run counter to many of psychiatry's most cherished notions.

To what extent is force legitimate in treating patients who are incarcerated because of illnesses that they do not recognize, or for which they wish to receive no treatment? We think that when one is confronted with such persons, one must first decide if such imprisonment is warranted and if it is not, the task is

to 'treat' society rather than the patient. But in situations where patients are quite properly being held against their will until they change, it seems humane and helpful to use force, at least to the point of increasing their range of choice, of increasing their awareness of themselves, and others, to the point where, as far as can be determined, what they do, they self-consciously choose to do. The validity of force depends on this assumption. If the process were one of eradicating a set of disapproved ideas and washing in different social values, then we would be committing offences as grievous as those involved in setting up the Third Reich – indeed, the more sinister, because of their subtlety. On the other hand, if our patients did not choose to deviate from society's norms, but rather were driven to such deviations by internal unresolved conflicts, then we should help them to resolve such conflicts by every means at our disposal, including force, humiliation, and deprivation, if necessary. Physical force brought the patient to our hospital, physical force maintains him there, and this force will not be lifted until he changes his behaviour in a recognizable way.

In our opinion, there is no question that the treatment necessary to produce some remission of the illnesses suffered by most Oak Ridge patients would be impossible on a voluntary basis.

True, it seems evident that in the traditional, autocratic hospital, the use of force is antitherapeutic in most cases (5, 14). However, it may be that the effect of force depends upon the motivation for its use, the way in which the motivation is conveyed from the agent to the patient, and the way in which it is perceived by the patient. If communication is maximized, coercion may be therapeutic, particularly when it is exerted by peers rather than authority figures. Our feeling was that force could most usefully be employed in treatment, particularly the treatment of the asocial and antisocial personality disorders; and that as communication approaches a maximum, the permissible use of force also approaches a maximum.

The Ward and The Program

The development of the program since September 1965 is of considerable interest, and merits separate treatment. It was rapid, turbulent, and frequently dangerous. In this paper, we will only attempt to describe the situation as it was for a period from November 1966 to February 1967. The ward structure and program arrangements remain flexible: that is, the number and composition of committees, programmed hours and types of programming, all fluctuate and change from month to month as the Unit evolves.

As has been said, the ward accommodates 38 patients. In February 1967 half of them were between 20 and 25, and the distribution of I.Q. scores approximated the normal curve. Legally, 13 had been charged with murder or manslaughter, nine with theft, five with assault or rape, and the remainder spread evenly through categories of arson, incest, indecent assault, extortion, and so on. Fourteen were diagnosed 'schizophrenics', a dozen 'pathological personality' or 'immature personality', and the remainder were borderline defectives and other classifications. Educationally, there was an even distribution between grades III and XII, with a few above and below. The vast majority of patients came from social classes 5 and 6.

Although there had been a number of transfers on and off the ward, twenty-two of the patients had experienced at least a year of the developing program by February 1967. All were involved in a minimum of 80 hours of structured interaction each week, all phases of which were compulsory. A variety of group interactions occurred which placed the patient in a number of different settings, with a number of different expectations.

Roles in work settings occupied about a third of the patient's day. All patients were employed either in industrial therapy or school. This work was compulsory, and with the exception of school, the emphasis was solely upon learning the basic requirements of the work situation: how to receive instructions and carry them out, how to make decisions, how to co-operate with others, and how the patient's pathology interferes with these things. No attempt was made at any 'vocational' training, since it seemed foolish to teach specialized skills to a man who did not know the basic skill of working.

All patients were members of one or another of the committees which managed the ward. Although modifications are made to the committee structure month by month, a fairly stable schema had emerged by February 1967. The major committees of seven patients each, Steering, Welfare, Medication, and Small Groups/crisis, were concerned respectively with program planning and organization, participation and sanctions, the management of all patient medication, and the arrangement and monitoring of all small groups (*ad hoc* therapy groups), together with the immediate handling of any crisis. Jointly, these committees initiated, sustained and planned the entire treatment program. A Planning Board met once each week to assess the last week, and plan the time-table for the coming week. A Policy Group, consisting of four patients, one professional staff member and one attendant staff member acted as the chief administrative unit for the ward, formulating all major policy and having the power of veto over the recommendations of all other committees. An Assessment Committee kept complete treatment files for each patient, showing medication, small groups treatment, sanctions, details of visits and mail and so on.

Twice a day, seven days a week, the entire community assembled for community meetings of 1¼ hours each. The first of these served as a feedback centre for work groups and committees: the preceding 24 hours were reviewed, committee decisions relayed and discussed. The second was concerned with the discussion of small group activities, focusing upon the problems of individual patients.

For an hour and a quarter each day on six days a week the entire ward subdivided into small groups which were assembled on the basis of individual patient needs. When a ward member was 'shook-up', as the patients say, that is, depressed or hostile, threatening to act out, etc., the Small Groups Committee formed a group of from four to eight patients who were considered the most suitable group for him to talk to under the particular circumstances of the crisis, selecting from among people who were involved, people who had experienced similar situations, his current friends or enemies. Small groups were also assembled to make periodic reviews of a patient's progress, to examine his motivation for a particular act, or to make specific recommendations that a committee did not have the time to consider at sufficient length.

For an hour each day, seven days a week, the ward subdivided into fixed dyads, and, for a further hour, fixed triads. That is, each patient was locked in a room with one (dyad) or two (triad) other patients. No patient was allowed to write, read, or sleep. He was expected to talk, or to listen. These dyads and triads remained constant: that is, the same groups of two and three people met for an hour in a locked room each day for as long as they were in the hospital. This sort of grouping was based on the assumption that in any close relationship a person will encounter obstacles to communication from which he may unhealthily choose to withdraw. If, however, he is forced to stay with the person or persons involved in the situation for an hour a day, indefinitely, he

is forced to solve the problem, usually by identifying those aspects of himself and the other person which created the difficulty.

The status of dyads and triads was discussed in dyad and triad groups of six patients, which subsequently fed back into dyad and triad ward meetings. Much of the most meaningful interactions took place in these groupings of two and three people, where the evolution of a relationship was made much more apparent to the partners by its forced continuity.

The patients often remarked that the unit was in the business of upsetting people, and that was true as far as it went. The process of anxiety-arousal, recognition and change was a central one, and was assisted by two major tools.

Video-tape: a closed-circuit TV/video-tape recording system was in use, providing a powerful resource for the objective observation of group dynamics. Small groups, dyads, triads, and ward meetings, could be observed 'live' without intrusion, or recorded and played back for analysis. The use of a zoom lens enabled a sophisticated operator to concentrate on many events that would have been lost to the most alert participants.

Demystifying drugs: From March 1966 to February 1967 a gradually increasing number of drugs were used to help uncover unconscious feelings in patients who were willing to undergo such an experience. All were. A complex system of safeguards became elaborated around their use. The need for such a system is evident where 30 mg. of methedrine and 1/75 gr. of scopolamine are injected twice a day for four days. Sodium amytal, scopolamine, methedrine, imipramine†, and dexedrine, were all used either singly or in combination to reduce defences. Concomitantly, efforts were made to reduce the use of tranquillizers to an absolutely necessary minimum. We employed the term 'demystifying drugs' to express something of the purpose in using them, adapting a term coined by R. D. Laing (10).

From November, 1966 to February 1967 three to five patients at a time were undergoing continuous courses of treatment with these drugs. Prior to that time, they were administered in single doses only, with gaps of weeks or months between doses. In the latter phases the drugs were administered daily for periods of up to two weeks. During the period of reaction, which might extend for a month after the last treatment, patients continued to participate in the program, and were observed for 24 hours daily by their fellow patients. In the daytime a disturbed patient was secured by a locked canvas wrist strap to a series of patients in four-hour shifts set up by the Small Groups Committee. Again, tactical use was made of the disturbed patient's friends and enemies, for being handcuffed to another for long periods forces an inescapable interaction. At night, he was placed in an 'Intensive Care Unit' (ICU), accommodating up to nine disturbed patients who could be observed all night by six better-integrated peers. Two 'screened rooms' formed a part of this ICU, and were used both for sleeping, and for the daytime protection of very seriously disturbed patients. (A 'screened room' is a colloquialism for a standard Oak Ridge maximum security room with a barred front, which has been stripped of all furnishings and fitted out with a metal screen to prevent the breaking of windows.)

In January the ward appeared to be capable of treating up to five patients at a time with the 'demystifiers'. The use of combinations of scopolamine and methedrine proved particularly useful in reducing the defences of the psychopath, while dextro-amphetamine/imipramine†† appears to promise well for schizophre-

†Tofranil.

††Dexamyl/Tofranil. (Dexamyl is a combination of dextro-amphetamine plus amytal.)

nics. There was some apparent success with an almost ritual employment of sodium amytal. The use of LSD-25 began in February 1967.

Schematically, then, the program consisted of confrontation, anxiety-arousal, analysis, and support in committees, dyads, triads, and small groups, supported by community meetings, the use of demystifying drugs, and the feedback resources of video-tape equipment. There were several ancillary phases of evaluation and recreation. Roughly four hours a week were devoted to physical exercise: 5BX, floor games, soccer, football, volleyball, etc. Ward members were able to watch TV for four hours a week, if they wished. Regularly, a patient was conferenced by the Unit; his chart was read by the Unit psychiatrist, and a current assessment with treatment recommendations was made by a patient group selected by the Small Groups Committee, and usually consisting of his dyad partner, closest friend, enemy, and so on. It is an interesting fact that no patient has yet been considered fit for complete discharge by his peers. Progress reports were completed by a patient committee for each patient, and were included in the hospital file.

For most of the day, then, the patient was exposed to a twofold confrontation, with himself and with others. His role alternated rapidly between worker, committee member, helper, and patient. In some settings, he was treated. In some, he was the treator. Often, he might occupy both roles simultaneously. This sort of alternation was at once an integrative and a disintegrative experience. The individual was forced to pull himself together, sanely, to help someone else. Often, in the process, his own insanity was exposed and pointed out by another, and he was forced to look at that also. For example, a patient while genuinely helping another might be using this as a defence against considering his own difficulties. Predictably on this ward messianism covers a multitude of sins!

But the time and the safeguards existed on the unit for each person to be as honest as he could be. In most settings, it would be considered a heinous crime to tell a suicidal patient that as far as one is concerned, he can go and hang himself. On the Intensive Treatment Unit there were always enough resources of genuine caring to allow for the full expression and examination of not-caring; what is more, not-caring is a part of reality with which the mentally ill person must learn to come to terms. Experience taught us that in a group of 38 patients, no one was ever without compassion from at least one other.

The Two Poles and The Field

The schematic program is one thing, but its description tends to obscure what is felt to be of value. Fundamentally, we saw it only as a means of setting up the space for dialogue, not as the dialogue itself.

In this space, an intensity of exchange was generated (7) from which a number of interesting phenomena arose. One of these was the creative tension that seemed to exist between certain diagnostic categories. The patients on the ward tend to speak frequently of schizophrenics and psychopaths – labels which convey to them not so much the illnesses psychiatrists refer to, as a common way of regarding two sorts of people, the way in which these people see themselves and others, and the way in which they act upon themselves and others.

The inability of the schizophrenic to describe the way he feels, and the further inability of the psychopath to draw on analogous emotional experience, have created a situation in many ways poignant for both personality types. It is perhaps a significant phenomenon that friendships on the ward tend to be formed across diagnostic boundaries rather than within them. The psychopath may feel himself to be confronted with someone, most of whose feelings and expressions tend to appear meaningless on some

levels. This meaninglessness, however, serves sometimes to underline his own inadequacies and needs. On the other hand, the schizophrenic meets a person who does not respond in kind, but who appears to be possessed of a particular type of self-mastery that accentuates the schizophrenic's own isolation. From this polarity arises a friendship often bristling with threats, but probably founded on the fascination for the foreign, the complementary. While it may seem unlikely that any *rapprochement* could take place on such a basis, we found it not only to be possible, but also most productive.

The mixture of diagnostic types on the ward was a major practical advantage as well, for the polarity referred to seemed to be a major impetus towards change. Intelligent psychopaths displayed great ability in observing details of behaviour, correctly describing it, proposing practical alternatives, and organizing activities. The schizophrenics offered much in terms of emotional support and empathy. For the individual, psychopath or schizophrenic, this combination provided a multi-dimensional picture of his situation, and a wide range of resources with which to fulfil his needs. The program seemed to be stabilized by this combination, which provides checks and balances, softening the raw practicality of the psychopath with the dreaminess of the schizophrenic, schizoid idealism with sociopathic politics.

Permissiveness

The myth of permissiveness often clouds the therapeutic community with its connotations of laxity, and it is worthwhile indicating that in many ways, helpful ways, the Oak Ridge Intensive Treatment Unit is considerably less permissive than a penitentiary. The influence of patient committees was exerted on all the daily activities of the patient. Where he went and what he did, from seven in the morning until ten at night, seven days a week, was determined by his fellow patients in a committee. The small group treatment he received, the medication he took, the penalties of his deviance were all fixed by the appropriate patient groups. He might be called upon by a committee to observe through the night in the Intensive Care Unit, be handcuffed to a dangerous patient, assist in carrying a man bodily to treatment, search a man for razor blades, or a room for broken glass. He might be deprived of his room, his clothes, his mattress, his coffee, or his tobacco, by a committee. As a last resort, he might be stripped by them, and locked in a screened room.

This is far from the sort of permissiveness commonly objected to, and more importantly it is at an extreme remove from the gangsterism of a reform institution inmate subculture. While a bald report of the activities of a patient committee may suggest the weekend pastimes of Storm Troopers, our explanation would be that a seeming rape is attempted in order to impregnate the patient with ideas that may prevent a further, more subtle, and more menacing rape: the rape that the illness perpetrates upon the patient, and the rape that a sick society maintains upon a few of its sicker members. If anything is being brainwashed into or forced upon Oak Ridge patients, it is, we think, the concept of an open system of evaluating, comparing, and questioning, rather than a closed system of revealed truths. It seems to be true, paradoxically, that in some forms of serious mental illness, force must be exerted to move the patient to a position where he can exercise free will, learn to evaluate and choose.

The Indefinite Hospital Sentence

To reach any dialogue to a degree assisting a man's discharge is not easy of course, and if our patients were to be together for only ninety days, then we would say that they might never attain it in a therapeutic form. But many of our patients were charged with serious offences before they were brought to Oak Ridge, and since the law demands

that before they are released there be more than a reasonable assurance that they will not burn, rape, kill or steal again, their stay in Oak Ridge is usually a long one, most often measured in years, and this makes the goal seem more attainable.

The 'indefinite sentence' is felt to be a most crucial factor in producing the anxiety to motivate change. Coupled with Buber, the possibility of a lifetime sentence is seen to offer greater chances of freedom than the iron subcultural brainwashing of a three year bit in penitentiary, where the squares and the rounders seem locked in a relationship of mutual strangulation. The possibility of five years spent in one meaningful stay in hospital seems more attractive than the prospect of twenty years worth of repeated sentences to a limbo of manipulations and sterile violence that progressively dwarf, harden, and anaesthetize the spirit.

Re-training for the World

It must be remembered that a man who has accustomed himself to speak with complete honesty about what he feels and thinks about himself and other people is regarded as something of a nut in our society, and will either make others very uncomfortable or be made so in turn by them. Although we have as yet had no practical experience in releasing a patient from our intensive treatment unit, we hypothesize at the moment that some period of readjustment will be necessary prior to discharge. During this time the patient will re-learn the social rituals and games that his stay in an intensive treatment unit has atrophied. In the summer of 1966, for example, two undergraduate students lived in the unit as 'patient participants' for two months. This was at a time when the program had not reached its full intensity, but even so the students were profoundly affected by their experience (6). One recorded that shortly after his release he was "impatient with superficial talk of any kind", and some time afterwards commented retrospectively that when he left he felt as if he was departing from a sane world populated by partly insane people, to go to an insane world populated by partly sane ones. While we do not feel that we are unfitting our patients for an alienated marketing culture, we do consider that it will take them a short time to adjust themselves to it. Laing's comments (11) on the craziness of contemporary society are most relevant in this context.

The Future

The impact of the community upon most patients has been considerable. With the exception of a few schizophrenics or defectives, definite changes seem to have taken place in all ward members. It is too early to judge whether these changes will be lasting, whether they are the prelude to integration, or whether they are simply the immediate product of the loss of privacy and the intense anxiety upon the ward.

Is exposure to a total experience of this sort helpful? We feel at the moment that two years of this intensive treatment may be of benefit to many patients, especially the young delinquents, not yet emotionally and socially ossified by one of our 'reform' institutions. But only an objective study will provide us with more than convictions about the nature of what is happening. To this end our task is to design and implement a research project that will evaluate the efficacy of this form of treatment. Such plans are under way now, so that what seems subjectively to be having an important effect on patients can be established as valuable or not on a rational basis.

* * *

"In human society, at all its levels, persons confirm one another, in a practical way, to some extent or other, in their personal qualities and capacities, and a society may be termed human in the measure to which its members confirm one another.

"The basis of man's life with man is twofold, and it is one: the wish of every man to be confirmed as what he is, even as what he can become, by men; and the innate capacity in man to confirm his fellow men in this way. That this capacity lies so immeasurably fallow constitutes the real weakness and questionableness of the human race; actual humanity only exists where this capacity unfolds. On the other hand, of course, an empty claim for confirmation, without devotion for being and becoming, again and again mars the truth of the life between man and man.

"Men need, and it is granted to them, to confirm one another in their individual need by means of genuine meetings: but beyond this they need, and it is granted to them, to see the truth, which the soul gains by its struggle, light up to the others, the brothers, in a different way, and even so be confirmed" (2).

Summary

This paper describes the structure and conceptual foundations of an intensive treatment program operated at the Ontario Hospital, Penetanguishene, a 304-bed maximum security institution which receives patients from the courts, reform institutions, and other mental hospitals.

The philosophy of treatment includes the following assumptions:

1) Mental illness is fundamentally a breakdown in the communication between persons.
2) For a sick person, the most helpful experiences are acts of genuine communication — direct encounters — as defined by Martin Buber, in which each turns to the other in his present and particular being, and addresses him without pretence.
3) The patient is the principal agent of therapy. He is equipped to help his peers better in some ways than the professional whose role is seen as an administratively supportive one creating the space in which direct encounter can occur.
4) Every event in a total institution should enhance the treatment goals.
5) The use of force is legitimate in treating patients for illnesses which they do not recognize, in settings where they will be incarcerated until they change.

An outline of the eighty-hour per week compulsory program describes the variety of group interactions, planned and sustained by patient committees with minimal staff supervision. The establishment of fixed pairings for an hour a day, seven days a week indefinitely as a device of confrontation; the use of video tape equipment as a device of observation; the intensive use of hyoscine hydrobromide, methamphetamine hydrochloride, imipramine hydrochloride, dextroamphetamine sulfate, amobarbital sodium, lysergic acid diethylamide as 'demystifiers' are sketched. Experiences in the simultaneous treatment of schizophrenic and psychopathic personality types are examined, and the need for the objective evaluation of results is affirmed.

The value of this program is felt to be primarily for those settings where patients are held for long periods of time.

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Résumé

L'auteur dépeint la structure et les fondements conceptuels d'un programme de traitement intensif mis en oeuvre à l'Hôpital ontarien de Penetanguishene, établissement à sécurité maximum de 304 lits, qui reçoit des malades envoyés par les tribunaux, les maisons de réforme et d'autres hôpitaux psychiatriques.

Les principes qui président au traitement se fondent sur les suppositions qui suivent:

1) La maladie mentale est en principe une rupture des communications entre les gens.
2) Pour une personne malade, ce qu'il y a de plus utile ce sont les actes de communication véritable – les rencontres directes – telles que les a définies Martin Buber, au cours desquelles chaque malade s'adresse à un autre, dans son état actuel et particulier, sans aucune simulation.
3) Le malade est le principal thérapeute; dans certains cas, il est mieux en mesure d'aider ses pairs que ne pourraient le faire des professionnels dont le rôle se voit comme un appui administratif créant l'ambiance où peuvent se produire les rencontres directes.
4) Chaque événement dans un établissement complet devrait renforcer les objectifs du traitement.
5) Le recours à la compulsion se justifie lorsqu'il s'agit de traiter des malades qui ne se rendent pas compte de leur état, dans des situations où ils seront incarcérés jusqu'à ce que leur attitude se modifie.

Un aperçu du programme obligatoire de 80 heures par semaine dépeint la gamme des interactions collectives, élaborées et maintenues par des comités de malades, avec le minimum de surveillance de la part du personnel. La création de groupes fixes de deux malades pour une heure par jour, sept jours par semaine et cela durant une période indéfinie de temps comme moyen de confrontation; l'emploi de magnétoscopes comme moyens d'observation; l'usage intensif de médicaments tels que le bromhydrate d'hyoscine, le chlorhydrate de métamphétamine, le chlorhydrate d'imipramine, le sulfate de dextroamphétamine, l'amobarbital sodique, le diéthylamide de l'acide lysergique, comme "démystificateurs", tout cela est brièvement décrit. L'auteur examine ce qui est arrivé lorsqu'on a employé simultanément le traitement des malades à personnalité schizophrénique et à personnalité psychopathique, et il soutient qu'on doit faire une appréciation objective des résultats.

On estime que ce programme est utile dans ces situations surtout où les malades sont détenus durant de longues périodes de temps.

I never saw a man who looked
With such a wistful eye
Upon that little tent of blue
Which prisoners call the sky

The Ballad of Reading Gaol

Oscar Wilde
1856-1900

THE TOTAL ENCOUNTER CAPSULE*

ELLIOTT T. BARKER, M.D.[1]
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For the last nine years, on a regular basis, groups of naked mental patients have been locked in a small room for periods ranging up to eleven days. In order to make the Total Encounter Capsule seem, if not a useful form of therapy, at least logical and not perverse, there is a need to provide some background information about this particular hospital, its patients and its programs.

The maximum security division (Oak Ridge) of the Mental Health Centre at Penetanguishene receives patients from the courts, penitentiaries, reformatories, jails, and psychiatric centres throughout the Province of Ontario. Three hundred hospital beds were provided to manage patients who cannot be safely treated elsewhere because of the seriousness of their legal situation or the presumed dangerousness of their psychiatric state.

In 1965 we began to develop intensive methods of group therapy which made maximum use of the resources of patients alone; programs which rested in part on the assumption that a genuine encounter between persons, in the terms of Martin Buber's "Turning Towards", was the aim and achievement of therapy. In Buber's words: "the basic movement of the life of dialogue is the turning towards the other . . . genuine dialogue — no matter whether spoken or silent — where each of the participants really has in mind the other or others in their present and particular beings, and turns to them with the intention of establishing a living mutual relation between himself and them" (4).

Development of patient run treatment programs was possible for three main reasons. First, most of the one hundred and fifty patients confined in the four milieu therapy wards possessed relatively intact personalities (not grossly psychotic or severely retarded); secondly, their length of stay was usually measured in years; and finally there had always been a low patient/professional staff ratio — never less than thirty to one. If a patient wanted to change, he could see that there were never enough psychiatrists, social workers or psychologists to try to give him much direct help.

The intensity of the original programs gradually escalated during 1966 and 1967 to the point where the patients on the most intensive treatment ward were participating in one hundred hours per week of structured interaction in a community whose emotional climate was frequently fueled with a battery of so-called defence disrupting drugs — Sodium Amytal, Amphetamines, Scopolamine, Dexamyl-Tofranil and LSD (3, 8). Such disruption of deeply entrenched defences made good sense for patients in Oak Ridge, where anything short of a major

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personality alteration might well mean lifelong incarceration.

By late 1967, it became clear that two main problems dictated the need for further changes in the programs that had developed. In the first place, although anxiety raising procedures may be good treatment from the point of view of personality change, the risks of homicide and suicide become very real in such programs. And this is especially so in a conventional hospital ward where patients have relatively easy access to steel bedsprings, sheets, chairs, forks, and spoons — a veritable armoury for anyone eager to act out on himself or someone else. As the level of anxiety continued to escalate in the programs, it became more and more likely that the elaborate system of safeguards and observers might fail (7).

The other problem was the phenomenon of patients, usually psychopaths, rising to the organizational apex of a therapeutic community without themselves being touched by the program. Glib, articulate, and well versed in the defensive "psychologese" that can cover the most radical conflicts by describing them impressively, they had become accustomed to operating with a minimum of discomfort in the highly structured programs. Intellectually, however, many of these patients had learned that they were indeed sick, and that the way out was to get well. It was these patients who were keen to team up with professional staff to make use of any resource possible to solve their dilemma. It was these patients who admitted that as long as they could retreat to the privacy of their own room at night, or escape with television or books, that even a one hundred hour a week program would still leave them unscathed. It was these patients who realized that a confrontation would be inescapably intense if each was in the physical presence of all the others continuously, for long periods of time. In part we were influenced by the work of George Bach who conceptualizes the Marathon therapeutic process as "a practicum in authentic communication, based on freedom from social fears conventionally associated with transparency" (1).

In October 1967, therefore, the Sunroom program was started with the purpose of involving volunteer patients, who had been relatively untouched by other forms of therapy, in a program that also provided increased safeguards against homicide and suicide. After eight months' experience with the operation of the Sunroom program (5), the Total Encounter Capsule was designed. It was to function as a place of undisturbed security where a small group of voluntary patients could focus upon issues they felt important enough to warrant the exclusion of the usual physical and psychological distractions, and the possible risks of suicide or homicide that might attend extremely intense personal encounters.

The Capsule is a specially constructed, soundproof, windowless, but continuously lighted and ventilated room, eight feet by ten feet, with a soft rug-over-foam floor, which provides the basic essentials — liquid food dispensers, washing and toilet facilities — and in which it is possible for a group of up to seven patients to live for many days at a time, totally removed from contact with the outside. The Capsule group is under constant observation, either through a one-way mirror in the ceiling and/or by closed circuit television, and a high quality audio amplifying system. Patient observers, trained specifically for this full-time job, work eight hour shifts, and have a wide variety of duties. They must keep a continuous supply of liquid food — soups, milkshakes, tea, coffee, cocoa — available to the group, regulate the temperature of the Capsule to comfortable levels at all times, record on video tape any interaction that is deemed significant enough to replay for the participants or staff, keep a continuous written record of events as they unfold, and intervene if it appears that physical acting out is imminent.

It was decided, as the ground rules for the first groups were being drawn up, that the patients would participate in the Capsule without clothes. This move was prompted partly by the experience of Paul Bindrim, a

psychologist working in California, who felt that the uncovering of the private parts of one's body might facilitate the uncovering of the private parts of one's mind, and partly because of our fear that clothing might be used in a dangerous manner.

It is hard to recapture, after nine years' experience, the initial excitement and anxiety of staff and patients alike who together planned and built the Capsule. The flavour of some of this thinking is reflected in an early consent form which asked among other things: why are you volunteering? are you under pressure from your ward to do so? what rewards or penalties do you see as a result of volunteering? and, are you willing to have the staff use tear gas "if an emergency arises"? There was much concern regarding suicide and homicide precautions, perhaps understandable considering everyone's inexperience with such an intense setting, coupled with the fact that all the patients had previously killed one or more people or had otherwise been associated with sufficient violence to earn their way into a maximum security mental hospital. There was considerable discussion over the use of tear gas to abort violence. In fact, the only time tear gas has ever been used in the Capsule was during a trial run with two patients who volunteered to try to sustain a strangle hold for thirty seconds after having been sprayed with two competing brands of tear gas! Moreover, instances of even minor physical acting out have been noteworthy for their rarity.

During the first six months of operation of the Capsule forty-seven patients participated in seventeen groups which ranged in size from two to seven patients (average four) and in duration from one to eleven days (average four). The patients ranged in age from fifteen to thirty-three years (average twenty-two) and in education, from Grade 3 to three years of university (average Grade 8). Eleven of the forty-seven participated in two different groups, and six in more than three groups. Two-thirds of the participants expressed a definite desire to re-enter the Capsule, 27 percent said they would definitely not want to return, and 7 percent were undecided. Ten percent felt the experience was of no particular value and 90 percent felt it was helpful and useful, saying such things as: "have come to have respect for others' feelings", "came to a closer awareness of my problems and the ways I keep people at a distance", and "learned more about how I affect people".

Included in the seventh group held in the Capsule was a reporter from a large daily newspaper, who had been invited by the hospital to do a story about the Capsule because of a fear that a less informed and more sensational press could distort its function and purpose sufficiently to force its closure (9, 12).

Over the years the Capsule has been used in a great variety of ways, usually with the basic objective of providing a treatment situation in which the patients could help each other to acquire an improved accuracy of perception of their own and others' feelings and ways of relating, where the direction and intervention of trained professional staff was at a minimum. The challenge was to prevent the group from falling into any of the many snares and pitfalls which commonly beset the life of a therapy group as the members move towards a deeper level of mutual trust and acceptance (2). In many of the groups, one or more patients are given one of the defence disrupting drugs. Frequently, prospective group members have been required to study and write examinations on material relating to feedback and role functions in groups. "Traditional psychoanalytic theory concerns itself mainly with internal conflicts of which the patient is unaware. The [human relations training] laboratory is concerned with conflicts arising out of a limited awareness of social relationships. Ineffective social behaviour can persist because the individual is unaware of its consequences. The laboratory creates opportunities to become aware of the effects of behaviour upon others by explicitly promoting an atmosphere of frankness" (11). The groups have often negotiated a specific "contract" with the staff regarding the frequency of coming out of the Capsule for solid meals or showers, and the method

of deciding when the group would disband. In general, our experience has shown that groups with a predetermined time for release from the Capsule tend to "coast". Frequently music has been piped into the Capsule as a diversion. For awhile a light plastic ball was used by the groups, but later rejected. There was an attempt to utilize two groups at the same time, one housed with a television monitor in the Sunroom next to the Capsule, while the other was in the Capsule, and then trading places every other day — each group thus being exposed to detailed analysis by the other. Human Development Institute encounter tapes (10) coupled with video-taped feedback of some of the sessions have been used. For a time groups used the Capsule wearing some clothing, but this was later rejected in favour of the earlier practice of nudity. Some groups were created so that especially skilled and experienced patients could intensively interact with an acute psychotic patient so that he could be managed without drugs or ECT. For a time an elaborate system of coloured lights was installed to signal the group to begin "mirror" groups. (The mirror group is a type of round robin procedure frequently used in the hospital in which each member, in turn, gives his opinion of himself with regard to a specific question and then comments on his perception of each of the other members of his group in relation to the same issue). Each "mirror" consisted of a printed list of questions, covering one of four possible areas of concern — personal feelings, role functions, feedback, and group continuance. Since the Capsule first became operational in August 1968, it has been the preferred place for the administration of LSD — a relatively peaceful environment in contrast to the noisiness of the pervasive prison steel and terrazzo architecture — where the unobtrusive and high quality audio amplifying system and closed circuit television are an asset.

Attempts to evaluate the effectiveness of the Capsule as a form of treatment are complicated by two things. The manner of its operation has continued to evolve and change over the years, reflecting the interests of professional staff and patients present at any one time. It seems too high a price to pay to fix a rigid format on so flexible a treatment facility in order to assist research. Secondly, patients participating in Capsule groups do so only for relatively brief periods of time, then are once again immersed in the intensive milieu therapy programs functioning on the Social Therapy Unit. To isolate the effects of the Capsule from the effects of these other programs would be difficult. A research project evaluating a program with the same basic objectives as the Capsule — a situation in which the participants could help each other to acquire an improved accuracy of perception of their own and others' feelings and ways of relating, where the direction and intervention of trained professional staff was at a minimum — has been completed. Participants in this program did show significant changes one year later as compared to randomly-assigned control groups (6).

The Capsule program† has not eliminated the problem of the escapist role-playing of the articulate psychopath, although it has helped. Its main contribution has been rather to provide a brief, very intense, but safe experience for a patient to look forward to or back upon as a bench mark during a lengthy stay in hospital. If nothing else, the Total Encounter Capsule has stood the test of time in serving this important function.

Summary

For the last nine years, groups of patient volunteers in the Social Therapy Unit of the

†It is of some importance to point out that the Capsule program was initiated and is still successfully operating in what to many is assumed to be the stultifying environment of a bureaucratically run government institution. While this is mostly a tribute to the administrative competence and bold concern for patients embodied in the then superintendent, B. A. Boyd, it is also a reflection of the higher government administrators and the politicians so often assumed to be too fearful of criticism to permit innovation. In this same context we are indebted to the Donner Canadian Foundation for generous financial support of this project.

maximum security section of the Mental Health Centre at Penetanguishene have been making regular use of the Total Encounter Capsule. The Capsule is a specially constructed, soundproof, windowless, but continuously lighted and ventilated room, eight feet by ten feet, which provides the basic essentials — liquid food dispensers, washing and toilet facilities — and in which it is possible for a group of up to seven patients to live for many days at a time, totally removed from contact with the outside. It functions as a place of undisturbed security where a small group of voluntary patients can focus upon issues they feel important enough to warrant the exclusion of the usual physical and psychological distractions (including staff), in a setting where the risks of suicide or homicide that might attend extremely intense personal encounters are at a minimum. The many ways in which groups of patients have used this facility are reviewed and the problems of researching the effectiveness of the program are discussed.

Included in the paper is an overview of the historical development of all the intensive coercive milieu therapy programs at Penetanguishene so that the purpose and function of the Capsule can be seen in context.

Designed initially as an attempt to overcome the problem of the escapist role-playing of the articulate psychopath, the greatest value of the Capsule is now seen more importantly as the way in which it provides a brief, very intense, but safe experience for a patient to look forward to or back upon as a bench mark during a lengthy stay in hospital.

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Résumé

Au cours des neuf dernières années, des groupes de malades volontaires de l'Unité de Thérapie Sociale d'une section à sécurité maximum du Centre de Santé Mentale à Penetanguishene ont utilisé régulièrement une Capsule de Rencontres Totales. Cette Capsule est construite d'une façon spéciale. Elle consiste en une chambre de 8′ × 10′, à l'épreuve du son, sans fenêtre, mais continuellement éclairée et ventilée. Elle satisfait aux besoins fondamentaux essentiels: dispensateur de nourriture liquide, facilités de toilette et de lavage. Il est donc possible pour un groupe pouvant atteindre 7 malades, d'y vivre pour plusieurs jours complètement isolés des contacts extérieurs. La Capsule représente un lieu de sécurité non troublé où un petit groupe de malades volontaires peut se concentrer sur des problèmes qu'il croit suffisamment importants pour se détacher des distractions physiques et psychologiques habituelles (incluant le personnel), dans un

lieu où sont réduits au minimum les risques de suicide ou d'homicide pouvant survenir dans des rencontres personnelles extrêmement intenses. On passe en revue les différentes façons dont la Capsule a été utilisée par divers groupes de malade et on discute du problème de l'étude de l'efficacité de ce programme.

On fait un bref résumé du développement historique de tous les programmes de thérapie dans un milieu coercitif intensif à Penetanguishene de sorte que le but et la fonction de la Capsule puissent être replacés dans ce contexte.

La Capsule avait été initialement conçue comme une tentative de solutionner le problème du rôle de retrait joué par le psychopathe habile à manipuler les mots. Toutefois, on constate maintenant que sa plus grande valeur est maintenant de fournir une expérience brève, très intense, mais sécuritaire pour un malade désirant un refuge qu'il peut utiliser durant un séjour prolongé à l'hôpital.

Brief Communication

LSD IN A COERCIVE MILIEU THERAPY PROGRAM*

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M.F. BUCK, M.D.[2]

Introduction

Over a four-year period thirty patients in a maximum security mental hospital were treated with LSD (500 mcmg. I.M.) to obtain some idea of the usefulness of this drug relative to Sodium Amytal, Methedrine, Scopolamine, and Dextro-Amphetamine Imipramine†, already in use in the hospital as so-called defence-disrupting drugs (4). In addition, we wished to obtain some idea of the comparative usefulness of LSD in the treatment of what could loosely be called psychopaths and schizophrenics, the two diagnostic categories we are treating. A local Advisory Committee appraised the ethical issues involved in offering the drug to volunteers in a coercive milieu therapy program (1, 2, 6, 7) and agreed to supervise the Project — a pre-condition for government approval to purchase LSD.

Administration of the Drug

LSD was administered only to patients who expressed high personal motivation to receive it and for whom, in the opinion of the treatment staff and the patient's peers, other methods of treatment were unlikely to be successful in expediting the patient's release from hospital. The prospective subject was obligated to obtain the informed written consent of his next of kin. Usual dosage was 500 mcmg. injected intramuscularly. On occasion it was found that intravenous injection of 15 to 30 mg. of Methedrine, two to six hours after the LSD, helped the subject to talk more freely.

All sessions were videotaped for the first four to ten hours. Other patients and staff were able to follow a session in progress from closed-circuit television monitors. The subject was fully aware of, and in agreement with, these observation arrangements. After the conclusion of the session, the subject was placed under 24-hour observation by his peers, and not left alone until he was judged not to be a risk to himself or others — usually a period of three to four days.

The interviewing procedure underwent several transformations, stimulated by our increasing awareness of the vulnerability of the subject to the biases imposed by the interviewer.

Medical Model

The patient lay on a standard hospital bed and was interviewed by a group comprising the male psychiatrist, a female nurse, and the patient's best patient friend. Attempts were made to evoke responses from the subject by providing a variety of stimuli — family photographs, a mirror, father and mother figures. We believed that on seeing the videotape records of the session a day or two later, the subject would be able to recall and discuss the feelings evoked by these stimuli.

Since many of the patients had killed or been violent prior to their admission, security concerns shared by staff and patients alike, led to the use of restraints (3). After administering the drug without

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†Dexamyl-Tofranil

serious difficulty to five patients who had killed and three patients who had been sexually assaultive, our anxiety decreased enough to discontinue the use of restraints. After twelve sessions conducted along this medical model, we seriously questioned whether or not the approach itself determined the course and nature of the patient's experience. Discussions with persons who claimed extensive use of LSD "on the street" suggested that the use of different procedures would influence the subject's experience in quite a different direction. We, therefore, experimented briefly with what may be called "The Responsible Street Model".

Responsible Street Model

The hospital bed was abandoned in favour of mattresses and cushions on the floor, and the room was liberally furnished with flowers, incense, and bright pictures. A record player with a large supply of popular "acid" music was used almost continuously. It was very surprising to find that vomiting could be terminated by encouraging the patient to "go with the music", usually a particular song — the Beatles' "All You Need Is Love". After only three sessions with this model, however, it was apparent to those of us with medical orientation, the great extent to which this interviewing procedure was influencing the subject's responses. Where, in the medical model, the subject was led through an underworld of father and mother figures, death, guilt, violence and insecurity, here, the subject was wandering through a usually pleasant but apparently equally imposed rose garden of pretty colours, fascinating sounds, and cosmic sentiments. We then turned to the final procedure, which was designed in an effort to minimize the influence of others on the subject's experience.

The Non-Directive Model

By mid-1968 we had developed the Total Encounter Capsule at the hospital in an attempt to provide a small quiet setting where highly specialized types of programs could be carried out (5). The "Capsule" is a specially constructed, sound-proof, windowless but continuously lighted and ventilated room, eight feet by ten feet, which provides the basic essentials — liquid food dispensers, washing and toilet facilities — and in which it is possible for a small group of volunteer patients to live for many days at a time, totally removed from contact with the outside.

In an attempt to remove as much as possible the input of "helpers" during the LSD session, we developed the following procedure. The subject would spend forty-eight hours in the "Capsule" with the patient friend of his choice prior to injection of the LSD. During this time the subject's main task was to review with his friend those aspects of his personality which he himself felt were most troublesome, least understood by him, and which he was hoping to gain some insight into with the drug. When the pair had become comfortable and settled in this different environment, LSD was administered and the videotape recording commenced. The subject's friend was instructed to offer no direction and to attempt no interpretation of any sort, but simply to "be with" and attend to his friend as empathically as possible. Frequently, but not always, patients chose a friend who had previously taken LSD in the hospital to be with them during their experience. During the following day, the recordings would be played back to the two patients who were encouraged to discuss them with one another. They usually left the "Capsule" some two or three days after the administration of the LSD.

Results

All the patients who received the drug felt that the experience was exceedingly beneficial and that they had obtained important insights into themselves. Other patients and staff could not see this subjectively reported benefit translated into an improved mental state or behaviour. Conversely, no one appeared to get "worse". Although only one of the thirty patients given the drug is still in Oak Ridge (1976), no one believed the LSD treatment

was instrumental in release. Of those released, roughly one-third are doing well, one-third are holding their own in the community, and one-third have been in further trouble.

"Chromosomal studies were undertaken on each of the patients in the LSD group as well as eighteen others of their peers on the ward who did not receive the drug. 'Blind' analysis on both groups showed that the LSD group had an increased frequency of breaks (7.4%) with individual maximums varying from 0.0 percent to 17.3 percent. The control group showed an average of 4.05 percent breaks with a range of 0.0 percent to a high of 5.7 percent. The latter frequency is similar to that routinely encountered in the cytogenetics laboratory. These findings are comparable to and complement other published studies, and while the biological significance of the breaks in cultured cells from LSD users is not known, it is unlikely that the chromosomal 'damage' produced by the drug will result in somatic malformations." (9)

Through informal contact with released patients, it is known that approximately 25 percent of the patients who received LSD in the hospital experimented with its use on the street after release. Given that one of our criteria for selection of subjects in hospital was their high motivation to receive the drug, and understanding the particular patients involved with usage later and the nature of that usage, it is the authors' opinion that the administration of the drug in the hospital was not a major factor leading to the patient's subsequent usage on the street.

Aggressive behaviour occurred with each of the three "interview techniques" — a total of six patients grabbing, punching or kicking at someone near him. There was not always a clear understanding of the meaning of this behaviour either at the time, or subsequently, by either the subject or those with him. All of the patients who acted out under the influence of the drug fell into the loose category of pathological personality.

LSD, perhaps because it is administered so infrequently but more likely because of its inherently fascinating effects, provides an event of considerable significance for the individual patient to look forward to, and back upon. It is difficult to give a concise statement of the nature of the subjective experiences of patients when under the influence of this drug, apart from saying that in every case it was intense, highly personal, not easily translatable into the King's English, and not readily observable. A perusal of Masters and Houston's book *Varieties of Psychedelic Experiences* gives one some understanding of the subjective experiences involved (8). In long-term treatment programs such a significant event is of value in itself, in the same way as has been found for other defence-disrupting drugs used in this hospital.

Conclusions

Using LSD in the manner described above we found no particular difference in its effects upon patients diagnosed as schizophrenic compared to patients diagnosed as psychopathic, with the exception of a propensity to acting out by the latter category.

Compared to the other so-called defence-disrupting drugs used in this hospital we would conclude that LSD is equally safe, but provides a more intense individual experience than the others.

Our experience with this drug indicates the great degree to which the content of the experience can be influenced by the interviewing procedure and the biases of the interviewer.

Summary

Over a five-year period, thirty patients in a maximum security mental hospital were treated with LSD (500 mcmg. I.M.).

Three different styles of interviewing procedure evolved with experience: a medical model, a "responsible street model", and a non-directive model. The interviewer's orientation appeared to significantly affect the patient's perception of the LSD experience. Since it was felt by the authors that no one set of biased inputs has any demonstrable merit over any other, (except in satisfying the interviewer), the

non-directive model was deemed most reasonable.

Although all patients reported that the experience was of great benefit, no one else could see changes for better — or worse. Chromosomal studies showed the usual increased frequency of breaks. It is noted that cytogenetic experts do not now see this finding as a contraindication to the use of the drug. It was not thought that the LSD administration in hospital was a significant factor leading to use of street drugs after release. The only difference on administration to psychopaths and schizophrenics was that one-third of the psychopaths (6 of 18) acted out by punching or kicking at someone nearby.

When used with the safeguards described, the drug seemed safe and valuable to use in our communities of long-stay patients, because of the high morale engendered.

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Résumé

Pendant plus de cinq ans, on traita avec du LSD (500 mcmg. I.M.) trente patients d'un hôpital psychiatrique à sécurité maximum. Comme l'emploi de cette substance ne représente qu'une facette d'un programme thérapeutique complexe et intensif dans un milieu coercitif, une vue d'ensemble du programme total est donc présentée.

L'expérience aidant, on développa trois styles différents de technique d'entrevue: un modèle médical, un modèle adapté (''responsible street model'') et un modèle non directif. L'orientation de l'interviewer a semblé affecter d'une façon significative la perception de l'expérience LSD par le malade. Comme l'auteur pensait qu'aucun ensemble d'influx de préjugés n'avait plus de valeur démontrable qu'un autre, sauf celle de satisfaire l'interviewer, le choix du modèle non directif a paru le plus raisonnable.

Quoique tous les malades aient rapporté que l'expérience LSD leur avait été d'un grand bénéfice, personne d'autre n'a pu constater de changements pour le mieux ou pour le pire. Les études chromosomiques ont montré l'augmentation habituelle de la fréquence des bris. On note que les experts en cytogénétique ne considèrent pas ceci comme une contre-indication à l'usage de cette drogue. On ne pense pas que l'administration de LSD à l'hôpital constitue un facteur significatif pouvant conduire à l'utilisation illicite de diverses drogues après la libération des patients. La seule différence observée lorsqu'on administre le LSD à des psychopathes et à des schizophrènes fut que le tiers des premiers (6 sur 18) réagirent en frappant du poing ou du pied quelqu'un qui était à proximité.

Lorsqu'utilisé avec les précautions décrites, le LSD semble utile et sécuritaire quant à son utilisation dans nos établissements pour malades à long séjour en raison du moral élevé qu'il engendre.

LIST OF RECORDS IN RESPONSE TO REQUEST
011129-M.O.H.

1. Memo from Dr. Boyd to Mr. L.C. Hales, dated March 22, 1976 – 2 pgs.
2. Memo from Dr. Boyd to Dr. D.C. Panday, dated March 30, 1976 – 1 pg.
3. Memo from Dr. Boyd to Dr. Maier, dated August 11, 1975 – 1 pg.
4. Memo from Mr. Moricz, to Mr. Klamer, dated July 15, 1976 – 1 pg.
5. Memo from Dr. Boyd to Mr. Moricz, dated July 15, 1976 – 1 pg.
6. Memo from Mr. Klamer to Mr. Moricz, dated July 9, 1976 – 1 pg.
7. Letter from Peter Ramsey to Mr. Klamer, dated July 7, 1976 – 1 pg.
8. Memo from Dr. Maier to Dr. Boyd, dated November 13, 1975 – 1 pg.
9. Memo from Dr. Boyd to Dr. Maier, dated August 11, 1975 – 1 pg.
10. Memo from Dr. Maier to all members of the Professional Advisory Committee dated July 24, 1975 – 3 pgs.
11. Memo from Mr. Moricz to Dr. Boyd, dated July 24, 1975 – 1 pg.
12. Letter from Dr. Maier to Mr. R.A. Graham, dated February 27, 1976 – 1 pg.
13. Article, "The Insane Criminal as Therapist" by Dr. Barker and M.H. Mason
14. Article, "Protective Pairings in Treatment Milieux: Handcuffs form Mental Patients" by Dr. Barker, Mr. Mason and Mr. Walls.
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Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Ontario

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September 27, 2001

David Rabinovitch
Unit 3, 2nd Floor
1001 Queen St. W.
Toronto, ON M6J 1H4

Dear Mr. Rabinovitch:

Re: Files Numbers 010930-MOH & 011129-MOH

Further to your telelphone conversations with this office on September 26, 2001, please find enclosed an index of records for File Number 011129.

Also, in regard to your request to view records from both your requests in order to determine which ones you require photocopied, please phone this office to make arrangements. You can phone me at (416) 327-3503 or Peter Meyler at (416) 327-7097.

In order to view records, you are required to pay the search fees for both requests. The fee is as follows:

011129 Search (1 hour @ $7.50 per 15 min.)	**$30.00**
010930 Search (3 hours @ $7.50 per 15 min.)	**$90.00**
Total	**$120.00**

Please send or bring a cheque made out to the **Minister of Finance** for a total of $120.00.

If you have any questions about the contents of this letter, please contact me.

Sincerely,

Dan Bryant
Program Adviser

Enclosure